



MINISTRY OF HEALTH MALAYSIA

COUNTRY HEALTH PLAN

10TH MALAYSIA PLAN

2011-2015

1Care for 1Malaysia

KEMENTERIAN KESIHATAN MALAYSIA

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PREFACE

Malaysia is a dynamic country which has enjoyed economic growth and political stability since independence 50 years ago. Malaysians are more healthy, have a longer life expectancy and productive. The level of overall health achieved is an indication of the success of the country. Good health allows Malaysians to enjoy a productive and meaningful life. Good health contributes to the prosperity and overall social stability.

The Country Health Plan: 10th Malaysia Plan 2011-2015 has detailed out the health plan for Malaysia. Much effort had been put into its development since it is first initiated in early 2008. Four Technical Working Group was established to address issues related to health services delivery, governance and financing, health awareness and healthy lifestyle and empowerment of individual and community to be responsible for own health. Ultimately the Tenth Malaysia Health Plan Conference was convened at Subang Holiday Villa Hotel from 2nd to 4th February 2010 involving participants representing all stakeholders in health sectors. This document is the summary and synthesis of the proceeding of the conference.

The plan to work together towards improving our health care system is based on the concept of 1 Care for 1Malaysia. 1 Care is a restructured national health system that is responsive and provides choice of quality health care, ensuring universal coverage for health care needs of population based on solidarity and equity. This Health Plan was formulated based on a deep understanding of the needs and challenges, the government's ability to finance it and value for money. It was developed to reflect the aspirations to achieve high-income country status by 2020.

The aim of the 1 Care for 1 Malaysia concept is to create an effective, efficient, fair and high-tech system of health care as well as responsive and can further improve access to various levels of appropriate health care to all Malaysians. For that reason, there is also a need to restructure the national health care financing and health care delivery system to ensure universal coverage of healthcare services which can be provided at reasonable cost using available resources as optimally as possible in delivering continuity of care across programmes, across healthcare settings and across healthcare providers. Achieving the Ministry's mission and goals will require sustained commitment. The plan will not only serve as a guide within the Ministry of Health, but will also provide a framework for other stakeholders to work together towards improving our health care system.

ACKNOWLEDGEMENT

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This Country Health Plan (2011-2015) document would not have been possible without the support of many people. Planning and Development Division Ministry of Health Malaysia wishes to express our gratitude and would like to place on record our appreciation and sincere thanks to the Secretary General of the Ministry of Health, the Director General Of Health, Malaysia, technical working group's chairpersons, members and rapporteurs, who were abundantly helpful and offered invaluable contributions, assistance, comments, suggestions, support and guidance. Deepest gratitude is also due to workshop participants and the respective Division directors for their contributions as well as the members of the supervisory committee who's without knowledge and assistance this document would not have been successful. Special thanks also to all colleagues, friends and individuals for sharing the literature and invaluable assistance who have in one way or another in producing this publication.

EXECUTIVE SUMMARY

Health care services in Malaysia is provided by various health care providers, from the public, private and Non-Governmental Organisations (NGOs) providing health care through conventional or traditional & complementary medicine. Although issues and challenges faced during the Tenth Malaysia Plan (10MP) may be similar to those in the Ninth Malaysia Plan (9MP), issues on globalization and the increasing trend of private health care spending poses a great challenge and concern on maintaining the strength of the current healthcare system.

Malaysia is still trying to recover from the current economic crisis. Trapped as a middle income country over a long period, for the 10MP, the government of Malaysia has set the target of achieving a high income nation by the year 2020. To achieve this target, Malaysia would have to make at least a yearly 5.5 % growth rate. The government has allocated a total of RM180 billion as development expenditure ceiling for all sectors where by RM 15 billion is for the Private Funding Initiative Facilitation Fund. Another RM50 billion (minimum) is expected to be contributed by private investments under the Private Funding Initiative.

To achieve Vision 2020 and in line with the 5 National Mission Thrusts (2006-2020), 6 National Strategic Directions have been identified to support these thrusts. These are:

1. Competitive Private Sector as Engine of Growth,
2. Productivity & Innovation through K-economy,
3. Creative & Innovative Human Capital with 21st Century Skills ,
4. Inclusiveness in Bridging Development Gap,
5. Quality of Life of an Advanced Nation and
6. Government as an Effective Facilitator

Although, the main focus of the health sector is to achieve 'Quality of Life of an Advanced Nation', the health sector has also some role to play in the other strategic directions. Quality Healthcare & Active Healthy Lifestyle has been set as the main Key Result Area (KRA) for the health sector for the 10MP. The outcome is to ensure provision of and increase accessibility to quality health care and public recreational and sports facilities to support active healthy lifestyle. Subsequently, four 10MP strategies have been identified. They are:

Strategy 1 : Establish a comprehensive healthcare system & recreational infrastructure

Strategy 2 : Encourage health awareness & healthy lifestyle activities

Strategy 3 : Empower the community to plan or implement individual wellness programme
(responsible for own health)

Strategy 4 : Transform the health sector to increase the efficiency and effectiveness of the delivery system to ensure universal access

Based on these four 10MP strategies, three KRAs for the health sector have been identified, consisting of:

1. Health Sector Transformation Towards A More Efficient & Effective Health System in Ensuring Universal Access to Healthcare
2. Health Awareness & Healthy Lifestyle
3. Empowerment of Individual and Community to be responsible for their health

The Ministry of Health (MOH) has been entrusted by the Economic Planning Unit (EPU) to identify Technical Working Groups (TWGs) under the Thrust 4 Mission Cluster Group (MCG) - Quality Healthcare & Active Healthy Lifestyle - involving inter-agencies and multisectoral membership. The Ministry has identified five TWGs

1. Health Sector Transformation (Service Delivery)
2. Health Sector Transformation (Finance & Governance)
3. Health Sector Transformation (K-economy – Human capital, Information Technology, Research & Development / Innovation)
4. Health Awareness & Healthy Lifestyle
5. Empowerment of individuals and community to be responsible for their own health

The outcomes, strategies and KPIs identified by the TWGs will be utilised to prioritise programmes, projects and activities in line with the National Programme finalised earlier by MOH and EPU:

National Health Sector Development Program

MOH has identified five health sector functional programmes:

- 1. Population Health Programme*
- 2. Personal Health Programme*
- 3. Research & Innovation*
- 4. Human Capital Development Programme*
- 5. Technical and Other Support Programme*

These five programmes serve as the mode to allocate funding for the 10MP.

PART I

PART I

THE TENTH MALAYSIA HEALTH PLAN (2010 - 2015) *'1CARE FOR 1MALAYSIA'*

1. INTRODUCTION

Since independence, Malaysia has seen tremendous improvements in its healthcare delivery system. The country now enjoys a fairly comprehensive range of health services provided by a dual system involving stakeholders from the public and private sector. Despite the dual system in healthcare provision, the government remains the main policymaking and regulatory body. The government's commitment towards universal access to affordable and high quality care is ensured by the dominance of public health services, which ranges from health promotion, illness prevention as well as curative and rehabilitative care. These would encompass both, allopathic and Traditional and Complementary Medicine (TCM) practices, at primary, secondary and tertiary levels of care.

The Economic Planning Unit (EPU) has identified 5 National Mission Thrusts to ensure that the nation's economic development is on the right trajectory to realize Vision 2020. The 4th National Mission Thrust is the improvement of the standard and sustainability of quality of life. The deliberations by the Mission Cluster Group for Key Result Area 2 (Ensure access to quality healthcare & promote healthy lifestyle) have attempted to reach a consensus on the more pressing gaps and identified key result areas and outcomes, and formulate strategies towards developing a plan towards the expected outcome (to ensure provision of and increase accessibility to quality health care and public recreational and sports facilities to support active healthy lifestyle) and for overcoming the obstacles.

The contribution of the health sector is primarily through provision of services that will lead to improved health outcomes and ultimately better health status of the nation. Tenth Malaysia Plan (10MP) stresses on quality healthcare and a healthy community and spells out a strategy that is geared towards the establishment of a comprehensive healthcare system and public recreational and sports infrastructure to support active lifestyles. The Ministry of Health (MOH), as the lead agency for health has been assigned to provide a more efficient and effective health system that ensures universal access to quality healthcare. In line with this, the MOH has developed a conceptual framework to restructure the health system. The restructuring proposal involves aspects of health services delivery, financing, enabling structures and its governance.

2. BACKGROUND

2.1 THE MALAYSIA PLAN

The Malaysian approach to developing the nation is via 5 - year plan. Initially it is called the Malaya Plan, which initiated in 1956. With Sabah and Sarawak joining Malaysia in 1963, the 1st Malaysia Plan was formulated and subsequently implemented in 1966.

The Malaysia health planning process has evolved from a purely top-down pragmatic approach into a mixed top-down, bottom-up process that is rational and evidence based. At the end of 7th Malaysia Plan (7MP), a more systematic approach to evaluating of plans was initiated. Subsequently, translation of policy-to-practice approach was developed and utilised in the 8th Malaysia Plan (8MP) with systematic monitoring and evaluation.

The objectives and strategies are measurable and create opportunities for greater integration of various health and health related agencies. This is further enhanced and improved during the Ninth Malaysia Plan (9MP) whereby a strategic planning approach was introduced. In the Mid Term Review (MTR) of the 9MP, the outcome-based evaluation was started.

2.2 NINTH MALAYSIA PLAN (9MP) AND EVALUATION

The theme of the 9MP was 'towards achieving better health through consolidation of health services'. This is consistent with the 5 National Mission Thrust namely Thrust 4 which is 'To improve the standard and sustainability of quality of life'.

The goals of the 9MP for health were divided into two primary goals and four supporting goals:

Primary Goals

- Prevent and Reduce Disease Burden
- Enhance Healthcare Delivery System

Supporting Goals

- Optimise Resources (including health human resource)
- Enhance Research and Development
- Manage Crisis and Disasters Effectively
- Strengthen Health Information Management System

In line with the Vision for Health statement that health is everyone's responsibility, under the 9MP, focus was given towards promoting lifelong wellness where individuals and families will be empowered to play greater roles in managing their own health, and hence to enhance the quality of life of the overall population.

The Outcome Based Assessment Approach was introduced during MTR of the 9MP. All government agencies and Ministries were required to ensure that projects and programmes conducted during the 9MP were in line with the 5 National Missions Thrusts as listed below:

Thrust 1 : To move the economy up the value chain

Thrust 2 : To raise the capacity for knowledge and innovation and nurture 'first class mentality'

Thrust 3 : To address persistent socio-economic Inequalities constructively and productively

Thrust 4 : To improve the standard and sustainability of quality of life

Thrust 5 : To strengthen the institutional and implementation capacity

The Fourth (4th) National Mission Thrust formed the basis of all health sector activities and programmes planned during the 9MP. During the Midterm Review healthcare services was suggested to be further enhanced with emphasis towards reducing gaps in changing disease patterns, between rural-urban services as well as meeting increasing demands of the population.

Recommendations also included increasing investment in activities that support health promotion, health education and healthy lifestyle practices. The delivery of healthcare should be affordable and easily accessible at all levels of care via collaboration among public and private sector and provide disease-oriented services. Primary and secondary care should focus on healing and recovery. There must be assurance that there are enough public sector health personnel. There is a need of collaboration among public and private sector in providing healthcare services to ensure optimum use of resources. Options should be made available to manage the increasing healthcare cost.

A 9MP Evaluation workshop was conducted to evaluate the progress of programmes and activities during the 9MP period. Methodologies used for the evaluation exercise was based on a mixed of qualitative and quantitative approach. The triangulation method was also used to obtain consensus owing to the lack of organized and appropriate data for purely quantitative evaluation. The findings was that there was a need for active sector stewardship to assist in developing more appropriate

end types of indicators that would be more useful for policy/health planning and decision-making. There were inadequate efforts towards consolidation of health services although it was the main thrust of the 9MP. It was also noted that human resource factor was given as the reasons for most non-performance during the 9MP.

3. HEALTH PLANNING PROCESS

Programmes and States were required to conduct situational analysis to identify gaps, issues and challenges pertinent and relevant to them. These issues and challenges were then prioritized. Subsequently, Technical Working Groups (TWGs) were formed to study each prioritized issue and to propose strategies for remedial actions. Details of this process are being elaborated in Part II of this document.

In-line with the framework as stated in this document, the Programme Health Plan were developed outlining the strategies, plan of actions and indicators for each Programmes. Papers related to these were discussed during the 10MP (Health) Conference. A consolidated health chapter report was written and incorporated into the 10MP EPU document.

4. HEALTH STATUS OF MALAYSIANS

The following is a summary of the population profile and health status for the country.

4.1 DEMOGRAPHY

4.1.1 Population, Gender and Ethnic Distributions

Malaysia has a land area of 330,803 square kilometres. The population density stood at 86 persons per square kilometre in 2010 compared with 71 persons in 2000. The population of 2010 is 28.3 million. That gives an annual growth rate of 2.0 %, for the period 2000-2010.

The highest population densities are found in Federal Territory of Kuala Lumpur followed by, Penang and Putrajaya (6,891, 1,490 and 1,478 per square km respectively) for the year 2010. The states of Sabah, Sarawak and Pahang had the lowest population densities (less than 100 per square km) for the year 2010.

Men outnumbered women with the sex ratio of 106. Similar pattern was observed in year 2000 (104). The ratio of males to females was relatively high for Pahang (113), Johor (112), Negeri Sembilan, Sabah, Selangor and Labuan 107 each and 106 in Sarawak, However men outnumbered by women in Federal Territory of Putrajaya (89), and Perlis (97).

Malaysia is a multiracial country consisting predominantly of Bumiputras (67.4%) followed by the Chinese (24.6%), Indians (7.3 %) and other ethnic groups (0.7%). Among the Malaysian citizens, the Malays were the predominant ethnic group in Peninsular Malaysia which constituted 63.1%. The Ibans constituted 30.3% of the total citizens in Sarawak while Kadazan/Dusun made up 24.5 % in Sabah. Approximately 8.2% of 2010 projected population is non-citizens.

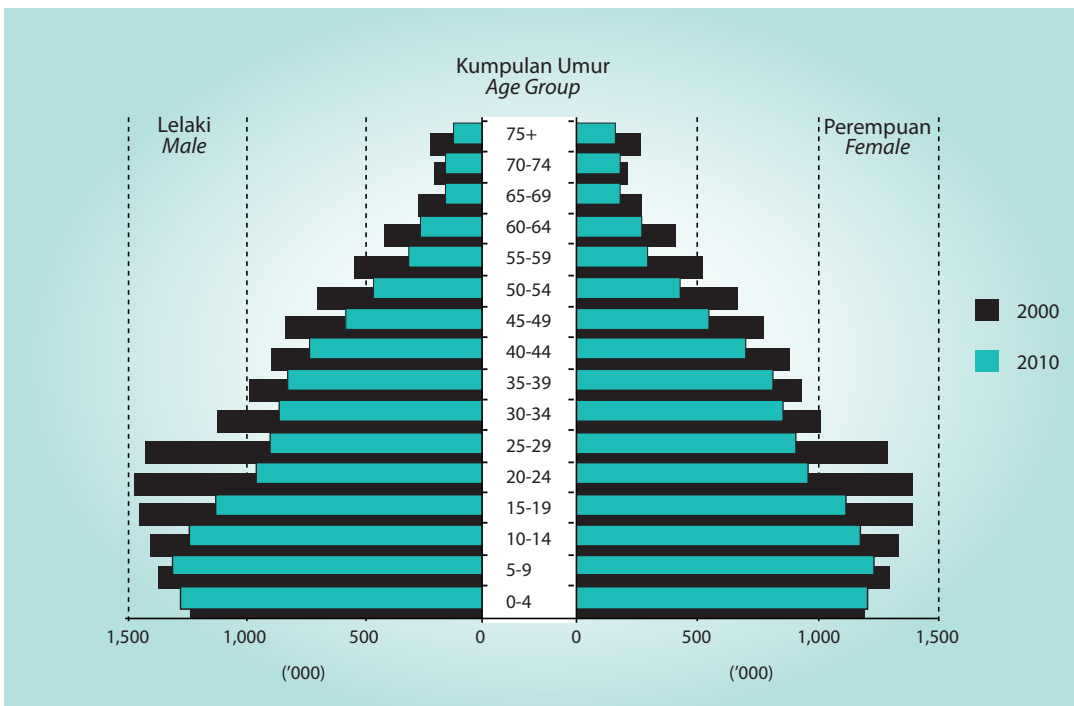
4.1.2 Rural-Urban Population Distribution

In tandem with Malaysia’s rapid development, the proportion of urban population has increased from 71.0% in the year 2010 to 62.0% in the year 2000. Apart from Federal Territory of Kuala Lumpur and Putrajaya with 100% level in urbanisation, the other states with high level urbanisation were Selangor and Pulau Pinang with 91.4% and 90.8% respectively. Conversely, the states with lower urbanisation levels were Kelantan (42.4%), Pahang (50.5%) and Perlis (51.4%).

4.1.3 Age Distribution and Dependency Ratio

Although Malaysia has a relatively young population, the proportion of the population below the age of 15 years has decreased to 27.6% compared with 33.3% in 2000. In contrast the proportion of working age population (15-64 years) has increased to 67.3% from 62.8%. The proportion of population aged 65 years and above also has increased to 5.1% as compared with 3.9% in 2000. Consequently, the median age has increased from 23.6 years in 2000 to 26.2 years in 2010, while the dependency ratio has dropped from 59.2% to 48.5%. The trend of these indicators is in line with the transition of age structure towards aging population of Malaysia.

Figure 1: The population pyramid for 2010



Source: Department of Statistics, 2011

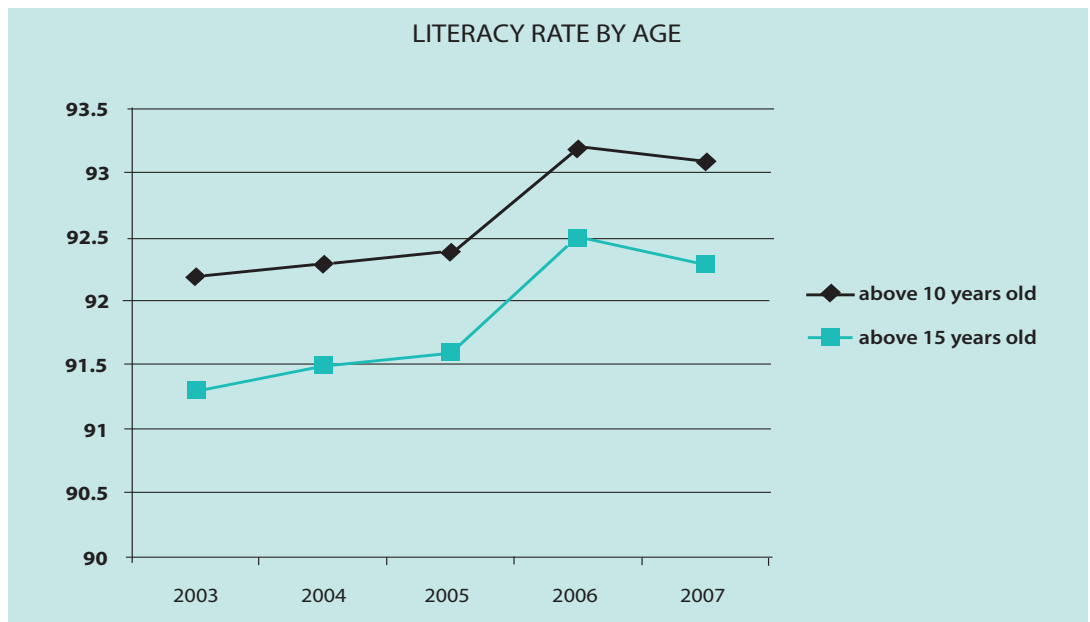
4.1.4 Immigrants / Foreign Workers

In 2010, there were 2.32 million non Malaysian citizens residing in Malaysia (DOS, 2011). That made up 8.2% of the total population for the year. In 2007, it was reported that 1.3 million foreign workers were registered with Foreign Medical Examination Malaysia (FOMEMA) and had undergone medical examination. Indonesians made up 46.66% (635,445) of that total. The rest of the foreign workers were from other countries particularly Thailand, Bangladesh and Pakistan. Sabah, Federal Territory of Kuala Lumpur and Selangor recorded the highest proportions of foreign workers, with 24.4%, 7.3% and 6.2 % respectively.

4.2 SOCIO-ECONOMIC STATUS

4.2.1 Education, Economic Status & Activities

Figure 2: Literacy Rate by Age from 2003 - 2007



Source : Health Informatics Centre

Literacy rate has increased over the years. The graph above shows that the literacy rate among those age 10 years and above have increased from 92.2% in 2003 to 93.2% in 2006 but dropped a bit in 2007 (93.1%). A similar trend is seen among those age 15-years and above.

The estimated labour force for 2009 was 12 142 000 equivalent to 66.9 % of the total population. Majority (52.6%) was from the service sector, followed by 28.4% in manufacturing, 12% in agriculture, 6.6% in construction and 0.4 % in mining. On the other hand, the estimated unemployment rate for 2009 was 4.5% (EPU and Department of Statistics) as compared to 3.6% in 2001.

The Gross National Product (GNP) for 2007 was RM 607,212 million Preliminary per capita annual incomes for the year 2008 was RM 22,345 (USD 6,726). The purchasing power parity per capita income for 2007 was USD13, 289. (WHO Country Health Profile)

The overall national incidence for poverty has reduced gradually over the past few decades. The overall incidence for poverty for the years 1990, 2000, 2004 and 2008 were 49.3%, 16.5%, 5.7% and 3.8% respectively. The incidence of hardcore poverty for 2004 and 2008 were 1.2 % and 0.8 % respectively.

Table 1 : Incidence of Poverty, Number of Poor Households, Incidence of Hardcore Poverty and Number of Hardcore Poor Household

Incidence/ Number	2007			2008		
	Total	Urban	Rural	Total	Urban	Rural
Incidence of poverty (%)	3.6	2.0	7.1	3.8	2.0	7.7
No. of poor households	209,000	76,400	132,600	224,700	79,000	145,700
Incidence of hardcore poverty (%)	0.7	0.3	1.4	0.8	0.3	1.8
No. of hardcore poor households	38,400	11,900	26,500	45,900	11,300	34,600

Source : Economic Planning Unit

Poverty incidence rates vary between states. In 2007, Sabah and Kelantan recorded the highest rate at 16.4% and 7.2 % with Selangor and the Federal Territory of Kuala Lumpur recording the lowest at 0.7 % and 1.5 % respectively.

Based on the population census carried out in the year 1980, 1991 and 2000 by the Department of Statistics and the National Population and Family Development Board (NPFDB) Malaysian Population and Family Survey 1994 and 2004, the average household size had decreased from 5.2 in the year 1980 to 4.5 in the year 2004 and the average age of marriage for a woman had increased from 23.5 years in the year 1980 to 25.3 years in the year 2004 (latest estimated figure).

Table 2 : Incidence of Poverty by States and Strata, 2004 and 2007

States	2004			2007		
	Total	Urban	Rural	Total	Urban	Rural
Johor	2.0	1.0	4.2	1.5	1.2	2.1
Kedah	7.0	3.0	9.8	3.1	1.5	4.3
Kelantan	10.6	8.3	11.8	7.2	6.9	7.4
Melaka	1.8	1.8	1.8	1.8	1.6	2.2
Negeri Sembilan	1.4	0.3	2.5	1.3	1.0	1.7
Pahang	4.0	1.1	6.6	1.7	0.9	2.5
Pulau Pinang	0.3	0.1	0.7	1.4	1.3	2.4
Perak	4.9	2.2	9.5	3.4	2.4	5.2
Perlis	6.3	5.2	6.9	7.0	4.8	8.3
Selangor	1.0	0.7	3.7	0.7	0.5	2.6
Terengganu	15.4	10.9	20.4	6.6	3.9	9.3
Sabah	23.0	12.9	35.6	16.4	8.4	26.3
Sarawak	7.5	1.7	12.9	4.2	2.3	6.3
WP Kuala Lumpur	1.5	1.5	-	1.5	1.5	-
WP Labuan	2.6	2.6	3.3	4.2	4.5	3.2
WP Putrajaya	-	-	-	-	-	-
Malaysia	5.7	2.5	11.9	3.6	2.0	7.1

Source : Economic Planning Unit

4.2.2 Amenities and Environment

Accessibility to health services can be further enhanced by improving existing amenities such as those supporting information and communication systems. In Malaysia there is a growing trend for the use of Information Communication Technology (ICT) as reflected by an increase from 15.8 per 100 populations with fixed telephone lines in 2003 to 18.1 per 100 populations in 2007, whilst the number of cellular phones per 1000 people had increased from 439 in 2003 to 944 in 2008. Meanwhile, internet subscribers per 1000 population was 114 in 2003 and increased to 143 per 1000 population in 2007.

The total road mileage had increased almost doubled from 76,800 km in 2003 to 122,127 in 2008. The coverage of clean water supply increased from 81.0 % in 1990 to 92.0 % and 95.5% in 2000 and 2008 respectively.

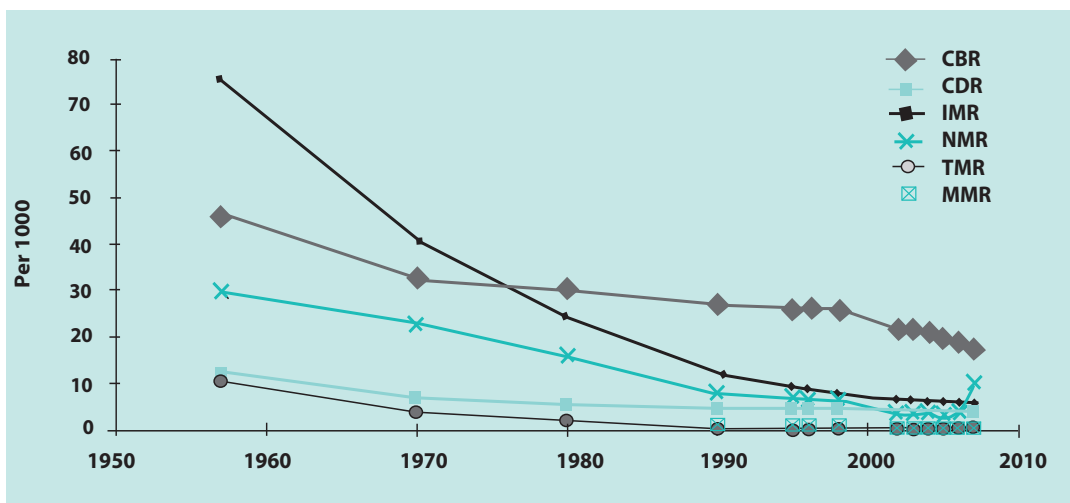
4.2.3 Quality of Life Index

The Malaysian quality of life index has improved by 15.6% in 2007 from the year 1990. The improvement was in all quality of life indices except for indices for environment and public safety which showed 4.5% and 20.6% decrease respectively. The crime rate per 1000 population has increased from 6.2 in 2003 to 7.7 per 1000 population in 2008.

4.3 HEALTH STATUS

The vital statistics for Malaysia has improved markedly since independence as noted in the figure 3 below.

Figure 3: Selected Vital Statistics for Malaysia



Source : Information & Documentation System Unit, MOH

4.3.1 Average Life Expectancy (LE) at Birth

LE¹ at birth for both genders has increased over the years. In 1990, LE for males and females were 68.9 and 73.5 years respectively. This had improved to 71.7 years and 76.46 years respectively in year 2007.

4.3.2 Crude Birth and Death Rates (CBR and CDR)

Crude Birth Rate² (CBR) has showed a decreasing trend. In 1990 it was 28.0 per 1,000 live births and reduced to 24.5 and 17.5 per 1,000 live births in 2000 and 2007 respectively. The Crude Death Rate³ (CDR) has also decreased from 4.7 per 1,000 live births in 1990, to 4.4 per 1,000 live births in 2000 and 4.5 per 1,000 live births in 2007. In the year 2000, the CBR was highest in Kedah at 7.9 per 1,000 live births and lowest in Sabah and Selangor at 2.5 and 3.0 per live births respectively.

4.3.3 Infant and Toddler Mortality Rates

Gradual improvement is seen in the Infant Mortality Rate⁴ (IMR), Perinatal Mortality Rate⁵ (PMR) and the Toddler Mortality Rate⁶ (TMR). The IMR showed an improvement from 13.1 per 1,000 live births in the year 1990 to 6.6 in 2000 and 6.3 in 2007. The Perinatal Mortality Rate also decreased from 13.0 per 1,000 live births in 1990 to 7.3 per 1,000 live births in 2007. The Toddler Mortality Rate decreased from 1.0 per 1,000 live births in 1990 to 0.4 in 2007.

¹Is the expected (in the statistical sense) number of years of life remaining at a given age

²Is the nativity or childbirths per 1,000 people per year

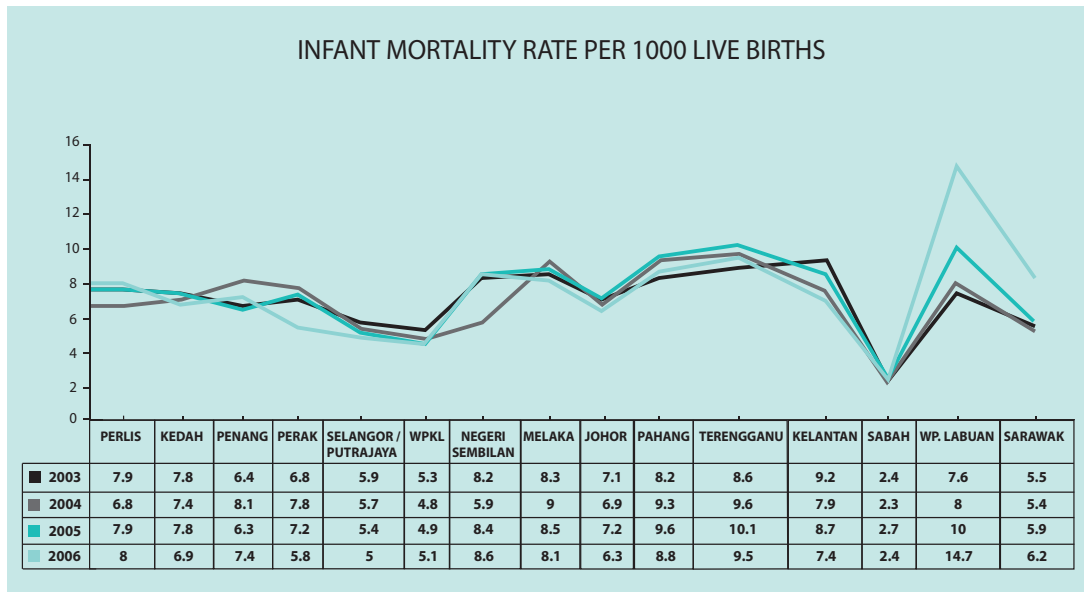
³Is the total number of deaths per year per 1000 people

⁴Is the number of deaths of children less than 1 year old per 1000 live births

⁵Is the sum of neonatal deaths and fetal deaths (stillbirths) per 1000 births

⁶Is the number of deaths of children less than 5 years old per 1000 live births

Figure 4 : Infant Mortality Rate for 2003 – 2006

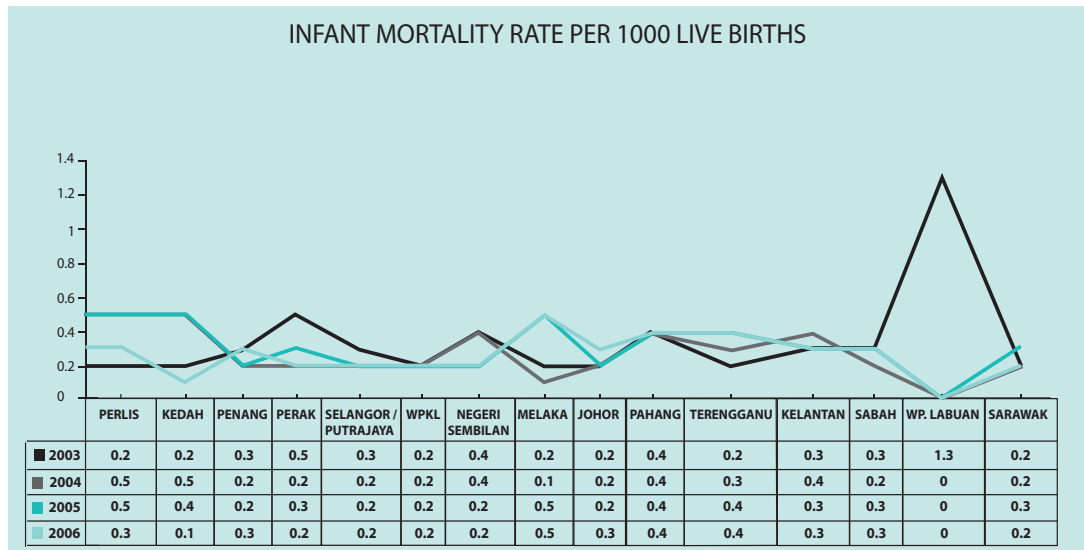


Source : Health Informatics Centre

4.3.4 Maternal Mortality Rate (MMR)

The Maternal Mortality Rate⁷ (MMR) remains at around 0.3 per 1,000 live births for the past 2 decades. Data for 2003 showed that WP Labuan had the highest MMR at 1.3 per 1,000 live births. In 2006, WP Labuan had no maternal mortality whereas Melaka had the highest at 0.5 per 1,000 live births.

Figure 5 : Maternal Mortality Rate for 2003 – 2006



Source : Health Informatics Centre

⁷Is the number of maternal deaths per 100,000 women of reproductive age in same time period

4.3.5 Admissions to MOH Hospitals

The total number of hospital beds in the public and private sectors has been increasing over the years. However the bed: population ratio for the year 2000 was 1:494 and worsened to 1:735 in 2008. The average bed occupancy rate (BOR) for MOH hospitals in 2001 was 60.0 %. This has increased to 65.5% in 2008.

The percentage of the population admitted to MOH hospitals varied significantly for various states. For example in the year 2003, Perlis and Negeri Sembilan had the highest percentage of admissions with 10.5% and 9.9% respectively while the lowest percentages were found in Kedah and Penang with 1.3% and 1.4% respectively.

The five main causes of hospitalisation in MOH hospitals for the year 2005 were normal delivery, complications of pregnancy, accidents, diseases of the circulatory system, and diseases of the respiratory system. Cause of admission in 2008 was similar to that in 2005 except that diseases of the respiratory system came in 4th hence displacing diseases of the circulatory system to 5th.

4.3.6 Mortality Pattern in MOH Hospitals

The top 5 causes of mortality in MOH hospitals in 2003 were heart disease and diseases of pulmonary circulation, septicaemia, malignant neoplasms, cerebrovascular diseases and accidents. In year 2008, the top 3 causes of mortality in MOH hospital remained the same while the fourth and fifth causes were pneumonia and cerebrovascular diseases respectively.

5. PROGRESS, ACHIEVEMENTS & SHORTFALLS

5.1 INTEGRATION EFFORTS

5.1.1 Integration across programs and activities

The National Strategic Plan for HIV-AIDS is a 5-year strategic plan against HIV-AIDS that involves all stakeholders and programs, and holistically encompasses preventive, curative, rehabilitative and promotive strategies and activities.

5.1.2 Public-private sector integration.

Initiatives in this area include:

- Outsourcing of medical services to the private sector (including radiotherapy services and emergency purchase of MRI, Computed Tomography Scan (CT-scan) and Intensive Care Unit (ICU) services from private hospitals)
- the employment of private specialists on a sessional or honorarium basis
- the Full Paying Patient Scheme introduced at Hospitals Putrajaya and Selayang which now makes it possible for MOH specialists to receive referrals from private hospitals at full paying patient rates
- the approval of locum practices for MOH doctors, which makes it possible for MOH doctors to now legally practice locum in private clinics with their Heads of Departments' approval – a win-win situation which hopefully will reduce brain-drain from the public sector.

5.1.3 Integration between different levels of care

The introduction of various telehealth (including teleconsultation and teleprimary care) and ICT initiatives in MOH hospitals and clinics, the e-reporting mechanism for data reporting in the Health Management Information System, and strengthening of the National Referral System are among initiatives aimed at strengthening integration between primary, secondary and tertiary levels of care.

5.1.4 Integration between different healthcare practices

The introduction of the Integrative Hospital concept at 3 hospitals (Hospitals Kepala Batas, Putrajaya and Pandan) on a pilot basis in 2007 was an attempt at integrating established traditional and complementary medicine practices into mainstream medical care at MOH hospitals.

5.1.5 Inter-agency integration and collaboration

An initiative, started in 2007 to introduce a Universal Emergency Number (999) for the whole country, has resulted in improved inter-agency integration and collaboration between the stakeholders involved, in particular between the MOH, Police, Fire and Rescue Department, Public Services Department, Telekom and other related agencies.

5.2 ACHIEVEMENTS IN PRODUCING HEALTHY PUBLIC POLICIES

5.2.1 Control of Tobacco Products Regulations in 1993

Numerous tobacco control activities have been implemented in Malaysia for the past two decades, with the enactment of the Control of Tobacco Products Regulations in 1993 as one of the most significant milestone. The most recent achievement is in enforcing the use of health warning pictorials on cigarette boxes, as has been implemented in countries such as Australia. By introducing pictorials and health messages on the box, the community is educated on the implications of smoking thus empowering individuals to choose not to smoke. In addition to the enforcement of this legislation, fiscal measures in increasing taxation on tobacco products were also introduced by the government. The World Bank recommends taxation of at least 65% - 80% of retail price. The current tax for cigarettes in Malaysia is about 40% of the retail price. Although increased taxation does not directly have an impact on empowerment of individuals and community, it does affect the smoking behavior. Nabilla et. al (2006) stated in a study in 2004 that the increase of cigarette prices by 10% has resulted in 3.8% decline in cigarette consumption in Malaysia.

5.2.2 Nutritional Labelling

In Malaysia, diet related health problems have increased dramatically over the last few years. To practice healthy eating, public awareness and knowledge on nutritional information is very important. Consequently, nutritional labelling has emerged as an important aspect of consumer's food purchase decision and it has been incorporated into the Food Regulations 1985.

The National Plan of Action on Nutrition in Malaysia was developed in 1996 to achieve and maintain nutritional well-being of Malaysians. The policy aims to provide access to adequate, nutritious, safe and quality food for all. The National Plan of Action for Malaysia (NPANM, 2006-2015) promotes and supports strategies for the practice of healthy eating. The policy will integrate and synergize efforts from relevant stakeholders in planning, implementing and evaluating food and nutrition programmes that are effective and sustainable.

5.2.3 Wellness Policy

The wellness policy has remained as one of the 8 healthcare goals since the 7MP. It has also been taken up as a TWG topic in the 9MP to change the focus from illness to wellness. As observed, chronic diseases are responsible for a high proportion of deaths and disabilities in all countries including Malaysia. In the Malaysian Burden of Disease and Injury Study (2003), about two thirds of the disease burden is contributed by non-communicable diseases which are related to lifestyle of individuals. Realizing this, the MOH embarked to promote early self risk assessment in the community and had shifted focus towards wellness and maintenance of health. In order to facilitate this move, a "Reviewed Approach" (REAP) concept was introduced in 9MP for primary healthcare. Primary Health Care services are carried out in an "integrated manner" whereby wellness and illness are being addressed simultaneously. An upstream care using integrated screening tools are given to clients to enable early risk identification and early intervention.

The Malaysian Government has also introduced the policy on routine medical examination for government servants aged 40 and above to encourage them to have regular medical check-up. In 2006, a total of 347 departments had participated and 22,759 staffs were examined. Of those being examined, 5,979 (26.3%) were noted to have at least one medical condition. Among the common medical problems detected were high blood pressure, obesity, high blood sugar and high cholesterol level.

5.2.4 National Breast Feeding Policy

Adequate nutrition is critical to child health and development. It's essential for optimum growth and general wellbeing of children. The MOH had formulated a National Breastfeeding Policy in 1993 and revised it in 2005 in accordance with the World Health Assembly Resolution 54.2 (2001) recommending exclusive breastfeeding in the first six months of life and continued up to two years. In addition, complementary foods should be introduced at 6 months of age. Through this policy the government is committed to protect current breastfeeding practices in the community from the impact of aggressive marketing strategies of breast milk substitutes.

In addition to the enforcement of code of ethics on breastfeeding, the Ministry of Health has also widely implemented the Baby Friendly Hospital Initiative since 1992 and to date there are a total of 128 Baby Friendly Hospitals in the country mainly within the MOH. Despite all these initiatives, the prevalence of exclusive breastfeeding amongst infants below four months has decreased from 29.0% in 1996 (NHMS II) to 19.3% in 2006 (NHMS III). Factors that do not promote breastfeeding include working mothers, decision on breastfeeding during pregnancy and lack of support from community.

5.2.5 Policies on Control of HIV and AIDS

In an effort to prevent the spread of HIV infection among intravenous drug users (IVDU), the Ministry of Health has embarked on the Harm Reduction Programme which incorporates Methadone Maintenance Therapy (MMT), Needle Syringe Exchange Programme (NSEP) and condom usage. The harm reduction programmes were carried out with the assistance from NGOs to strengthen community involvement and to increase acceptance among specific risk group. These programmes will empower specific risk groups in terms of mode of HIV transmission and methods of prevention.

There are also policies established specifically for the general population who are at risk of infection by the introduction of voluntary HIV testing at health clinics throughout the country. This will encourage the group at risk to come forward for testing and to get appropriate information and skills to protect themselves from being infected.

5.2.6 Food Hygiene and Safety Policy in Schools

Several policies and activities for schools were developed through the joint venture efforts between Ministry of Health and Ministry of Education under the “Program Bersepadu Sekolah Sihat” (PBSS). The aim was to empower the school community to ensure safe food for school children and prevention of food poisoning. Ministry of Health implemented ‘Program Pemeriksaan Sendiri’(KENDIRI) among operators in school canteens and school kitchen operators to empower them on aspects of food hygiene and safety since 2008. In 2009, about 75% of school canteens (5815 of 7770) and 54% (975 of 1821) of school hostel kitchens in Malaysia were involved in the program.

“Program Pengredan Premis Makanan” (PPPM) was introduced in 2008 to motivate them to achieve better grades that is a grade A or B. The result of inspection of school canteens and school hostel kitchens showed 23.5% obtained grade A, 45.5% grade B and the rest of the premises obtained grade C or D. As a result of these programs, the incidences of food poisoning in schools had decreased to 123 episodes in 2009 as compared to 230 episodes in the same period in 2008.

5.2.7 National Medicine Policy

Quality used of medicine is the fourth component in National Medicine Policy that was approved by the cabinet in October 2006. Government, industry and media activities in support of informed and appropriate use of drugs by consumers would promote better quality of care and cost effective therapy.

5.3 PROGRAMMES INITIATED TO EMPOWER THE COMMUNITY

5.3.1 Young Doctors Programme

This programme was introduced in 1989, is a school-based health promotion programme for primary school children to empower them with knowledge and skills to improve their health status. It is aimed at producing a group of students who would become role models and act as agents of change to promote good health among peers, the school community and family members. As of June 2009, 1058 schools have set up their own Young Doctors programme with 28,796 young doctors. (ref: Reten Program Doktor Muda, Jun 2009). This programme has been taken up by the Ministry of Education as part of their co-curricular activity in primary schools since 2007. (ref: Pekeliling Bahagian Sekolah KPM KP (BS/HEM) 8614/062/E (14) dated 23 May 2006).

5.3.2 Program Sihat Untuk Remaja (PROSTAR)

The introduction of PROSTAR in schools and PROSTAR Club in the community in 1996 was to empower adolescents to act as peer educators in healthy lifestyle. Initially, the programme was aimed mainly at HIV/AIDS prevention, but since 2008, a revised module was introduced which covered a wider range of topics for adolescents' health. The scope of the new module encompasses HIV & AIDS, Physical and Environmental Health, Mental Health, Sexual and Reproductive Health and Risky Behaviours. As of 2008, the number of PROSTAR clubs throughout the country has increased to 1,664 (ref: Health Education Division 2009 KPI Report).

5.3.3 MyHEALTH Portal

This portal was developed by the Ministry of Health under the Multimedia Super Corridor (MSC) Telehealth Flagship Application. Through this portal the public will be able to access current health information and health advice easily via the internet. This portal carries certain health-related topics such as Health for Kids; Teenagers; Prime Years; Golden

Years; Nutrition; Medication and You; Oral Health Alert; Frequently Asked Questions (FAQ) and also maintains a Health Forum. The number of hits for the portal at the end of August 2009 was 697,538. An average hits per day was 542 and the average weekly hits was 3,787. There are now 6,111 registered users and 7,210 people having interacted with health experts.

5.3.4 Healthy Lifestyle Campaign

The MOH had started a Healthy Lifestyle Campaign since 1991 carrying the theme “Be Healthy for Life” emphasizing on community roles, regardless of age and sex, to lead a healthy and wholesome lifestyle. The campaign emphasizes five main components, which includes healthy eating, managing stress, adequate exercise and physical activity and not smoking. Annual media campaigns have been conducted since 2006 to assess the achievements of the Healthy Lifestyle Campaign. 64% of people do physical activity or exercise in one form or another. 74% practice healthy eating, 85.6% practice healthy lifestyle to curb stress, 72.8% avoids alcohol drinking and only 17% are serious to stop smoking. (Healthy Lifestyle Media Campaign & Smoking Cessation Media Campaign 2006/2007).

5.3.5 Communication for Behavioural Impact (COMBI)

COMBI is an approach that can be utilized to mobilize communities for disease prevention. In Malaysia, this approach is used to empower the people in dengue prone areas via mobilizing their community and resources in planning and implementing activities aimed at the prevention and control of dengue outbreaks in their areas. As of early 2009, a total of 575 COMBI projects have been implemented throughout Malaysia, of which, 421 (73%) remain as active projects. During the period of January to June 2009, the number of cases in 470 localities practicing COMBI was monitored. Finding showed that there were 337 (72%) localities with reduction in number of cases, 30 (6%) localities with increasing number of cases and 103 (22%) remained the same as compared to the same period of time from January to June in 2008. (Vector Borne Disease Control Unit, Ministry of Health, Third Vector Technical Meeting 2009).

5.3.6 Quit Smoking Clinic

Smoking cessation services provides assistance to smokers through counseling and pharmacotherapies. These services are widely available throughout the country with the establishment of 294 Quit Smoking Clinics. In addition, the tobacco “Infoline” by the Health Education Division was provided further access to cessation assistance for smokers. As of October, the ‘infoline’ has answered 720 calls. (Smoking Cessation Infoline Yearly Report 2009).

5.3.7 Stop Smoking Campaign (Kempen Tak Nak Merokok)

The “TAK NAK” Campaign was made widely visible to Malaysians in both rural and urban areas through the mass media. There were evidences that the “TAK NAK” campaign had brought fear for smoking and had influenced smokers about quitting and had reduced the likelihood of smoking uptake among non smokers, particularly adolescents. The National Health Morbidity Survey (NHMS) III noted that there was a reduction in smoking in all groups (adult smokers from 24.8% to 22.8% and adolescent smokers from 11.7% to 8.7%).

5.3.8 Nutrition Information Centers and Healthy Community Kitchen (Dapur Sihat)

Nutrition Information Centers were set up at the National and State levels to promote healthy eating concepts. It promotes infant and young child nutrition, adolescent nutrition,

nutrition in institutions and adult nutrition through healthy eating, and nutrition for elderly and those with special needs. It acts as a center for reference for the public to gain access to nutrition information. Currently, there is a total of 14 Nutrition Information Centers throughout Malaysia.

The Healthy Community Kitchens were established in health centres within the Ministry of Health. Currently in Malaysia, a total of 48 Healthy Community Kitchens are operating. It helps to empower the community by educating on food choices and cooking methods to improve their nutritional status. A total of 17,602 people have utilised this healthy community kitchen up until September 2009.

5.3.9 Know Your Medicine

The Malaysian Government, through the Ministry of Health (MOH) developed a comprehensive strategy to promote rational medicine use among consumers, known as the Comprehensive National Strategy for Quality Use on Medicines (QUM) for Consumers since late 2006. A key principle of the strategy is the primacy of consumers in any initiative to promote QUM. This strategy was planned in tandem with the aspiration of one of the important components in the Malaysian National Medicines Policy which directly stresses the importance of the QUM concept among consumers of this nation.

6. ISSUES & CHALLENGES IN THE TENTH MALAYSIA PLAN

Multiple issues threaten the performance and sustainability of Malaysia's health system against a background of rising health expenditure. Underlying the challenges facing Malaysia are several unique features of the health system itself which provides universal coverage through a network of providers and payers with a growing public-private dichotomy. In the meantime, expectations and demand for care keeps rising and there is increased public scrutiny.

The health system has some control over the supply for health services but not much on the demand for healthcare services. Consequences include inequity in access to health services, inappropriate interventions and treatments as demanded by patients or induced by providers, varying quality and standards of care and costs that cannot always be effectively controlled.

Malaysia, in realizing these problems, has taken steps to correct them. Interrelated shortcomings need to simultaneously be addressed too. Among the shortcomings are inadequate information on service-mix, costs, and evidence especially from private sector to diagnose the problems; some solutions were unable to have desired and sustainable impact as they failed to adequately address the root causes; and political considerations make these efforts difficult.

Summary of Issues

- **Healthcare delivery**
 - Public-Private Dichotomy and other Structural Factors
 - Accessibility to Services
 - Responsiveness
- **Quality and Standards of Care**
 - Variations in Quality
 - Pursuit of Affordable World Class Quality and Standards of Care
 - Inappropriate Utilisation

- **Rising cost of care**
 - Inefficiency
 - Increasing demand for health services in institutions
 - Wasted resources
- **Cost drivers**
 - Wealth
 - Epidemiological transition
 - Facing emerging / re-emerging infectious diseases
 - Demographic transition
 - Technology
- **Financing the system**
 - Financial crisis
- **Health Awareness and Lifestyle**
 - Knowledge – behavioral gap
 - Community's reluctance to take ownership of health issues
 - Insufficient number of health promotion workforce
 - Lack of supportive environment
- **Empowerment of individuals and communities**
 - Constraints in implementing healthy public policy
 - Weakness of legislation and enforcement
 - Policies of other Ministries not in line with MOH
 - Lack of public awareness
 - Weaknesses in Programme Implementation
 - Constrains in empowering women and specific risk groups
 - Lack of supportive environment
 - Lack of resources
 - Organizational issues
- **Information and Communication Technology**
 - Inadequate integrated planning of health information system
 - Lack of health informatics expertise (subject matter experts and technical experts)
 - Inadequate infrastructure
 - Lack of standards
- **Research**
- **Human Capital Development**
- **Mismatched supply and needs / demands**

6.1 HEALTHCARE DELIVERY

The nation's formula of a public sector health system emphasizing on primary health care and having in place a good referral system for the populations to access the appropriate level of care has worked well. The government has strived to achieve equity in access and provided a comprehensive range of affordable and quality care. At the same time, it has not neglected services that are in the realm of public goods. However, with a growing private sector, many areas of concerns have emerged that need to be addressed urgently, namely:

- An imbalance in the distribution of resources and workload with the public sector shouldering a greater workload in terms of complexity and number of patients, particularly in-patients.

- In 2008, although only 11% of primary care clinics were publicly owned, they handled 38% of total patient visits. While there are more hospitals in the private system, the reality is 78% of hospital beds remain within the public system, attending to 74% of admissions. Through concerted effort, 55% of doctors are now within the public system. Grossly, the efficiency factor comes to mind as expenditure on healthcare is higher in the private sector.
- The problem of doctors in particular the more experienced specialist opting for the more lucrative private sector, resulting in shortages in the public sector
- Standard of care is not uniform and large variation in practice occurs in the private sector. The MOH is guided by a transparent quality assurance programme.
- Inequity in the distribution of facilities, with the private sector concentrated in the more urban areas and providing mainly curative care.

Other governmental agencies such as the Universities, Ministry of Social Welfare, the Local Governments and others are also involved in providing selected healthcare services. The issue behind this is how to integrate the healthcare services provided by these agencies and the MOH so that they do not duplicate but complement each other.

6.1.1 Public-Private Dichotomy and other Structural Factors

Managing the public–private dichotomy also poses a challenge. Over the past few decades, the private health sector has been growing very fast and playing increasing role in the provision of health care for the country. In 2008, there were 209 private hospitals with 11,689 beds. There were 22 private maternity homes, 12 private nursing homes and 3 private hospices, with a total number of 553 beds. There were 15,096 doctors in public health sector while 10,006 doctors in private health sector accounting for 40% of the total number of medical practitioners, but private hospitals beds only accounted for 22.8% of the total hospital beds in the country.

It has been observed that questionable quality of care; service standards and high fee charges in private health sector have been drawing the attention of society. Same questionable care and service standards are observed in some public hospitals.

Collaboration with the private health sector in disease reporting and outbreak response has not been strong and sufficient, for example, timely reporting of Sexual Transmitted Infections (STI) and dengue. Integration of primary, secondary and tertiary services through development of strong public and private partnerships and strengthening enforcement under the Private Health Care Facilities and Services Act 1998 (PHFSA 1998) are strategic challenges. There are also organizational issues in health services delivery and financing that require restructuring - not just merely increasing resources, improving implementation and enhancing processes. Thus, the need for health reform is indeed real and very challenging.

6.1.2 Accessibility to Services

Equity and accessibility to healthcare services has always been the commitment given by the government. The public sector delivery system subsidizes nearly 95% of the patients' cost of treatment for nearly 90% of the population that has access to some form of care. However, long queues for outpatient services, diagnostic procedures like CT- scan examinations, treatment modalities like endoscopic surgery and rationing of drugs for chronic diseases is a form of inequity. This inequity also relates to the doctor-population ratio whereby the population in urban areas like Klang Valley has more accessibility to doctors compared to the population in Sabah and Sarawak.

The existence of a dual healthcare delivery system has been promoted in part by the prevailing financing mechanism. With consumer affluence, the reliance of the population on highly subsidized public sector healthcare delivery system has decreased. This phenomenon has accentuated the disparity between public-private healthcare systems and put affordability as a key driver to accessibility for private health care services as even those who cannot afford private health services are demanding access to them. In trying to match the private sector, the public sector has to continuously raise the quality and standard of care and thus the cost of care.

6.1.3 Responsiveness

Our research indicates that Malaysia's health system, like those in many other countries, has come under considerable stress and that its sustainability is in question. The conspicuous absence of a way to allocate health resources equitably, effectively and efficiently e.g. doctors, makes it harder and harder for many marginalized patients to get services they need, promptly it. For example, there were reports of emergency rooms in the private sector turning away patients who needed emergency care.

World Health Survey 2002 showed that the goals of improving health and responsiveness were rated most important. Responding to problems related to the distribution and delivery of healthcare services are difficult challenges. Inpatient care, choice of care provider, prompt attention (waiting time and travel time), space of basic amenities, social support and autonomy (treatment information and involvement in decision making) were domains that fared poorly. Of those who had visited a health care provider, 80.9% (78.3-83.6%) had seen a medical doctor. The lowest income group, other ethnic groups, those with primary or no education and the uninsured had lower rates of seeing a medical doctor. Almost all (94.5%) who went to a privately owned facility saw a medical doctor, compared to only 62.7% of those who visited a government-owned facility.

6.2 QUALITY AND STANDARDS OF CARE

Rising consumer affluence together with well-informed patients has resulted in changing patient expectations. This reflects an improved understanding by the majority of the population of their rights. Patients expect quality care in a timely manner. However, this high expectation places an additional workload on delivery of services; where raised expectations of services require both improved practices and improved resources if they are to be achievable or sustainable.

The importance of quality and standards of care is without question. Important quality and innovation will attract inward investment and generate income to the nation through many opportunities in the health sector and industry e.g. health tourism, but pose challenges in marketing and branding. The MOH has an established and transparent quality assurance programme but this is not the case in the private sector. Consumer bodies has frequently lamented on the high drug prices and alluded to expensive private hospital care making it unaffordable to the majority of the population. Professional bodies have alerted the authorities regarding bogus and unqualified personnel in private clinics and have maintained that the standards in the Private Health Facility and Services Act 1998 (PHFSA 1998) should apply through the board, private as well as public. There is an urgent need to ensure clinical governance in the private sector.

6.2.1 Variations in Quality

Given the health system's inadequate regulations and/or enforcements over health professionals and hospitals especially in the private sector, it is not surprising that the quality of care varies markedly. Four factors help explain this variability.

First, research has repeatedly shown that outcomes are better when the centers and doctors responsible for procedures undertake large numbers of them. Many of the private hospitals and specialists cannot achieve the necessary scale.

Second, Malaysia's specialty credentialing and privileging is in place but implementation is still weak as doctors receive their medical licenses for life, with no requirement for renewal or recertification, except for the annual practicing certificate issuance, and in many cases the requirements or criteria are much less stringent than they are in many of the developed countries.

Third, the system lacks incentives to improve the quality of care and productivity. Further, unlike in the public sector, the private sector does not have a systematic collection of treatment or outcome data, like the National Indicator Approach in the Quality Assurance Program in Ministry of Health (MOH) hospitals, and therefore has no means of implementing mechanisms promoting best-practice care, such as pay-for-performance programs. Similarly, it has no way to enable hospitals or physicians to compare outcomes or for patients to compare providers when deciding where to seek treatment.

Finally, quality of care suffers from delays in the introduction of new treatments. Specialists are too often overworked to participate easily in clinical trials or to investigate new therapies. And because the country has few controls over hospitals, it has inadequate mechanism requiring them to adopt improvements in care. Furthermore, the sections responsible for approving effective new drugs and devices is understaffed, which may delay the introduction or wide adoption of some new treatments for several years even after they are approved and adopted in the United States (US) and Western Europe.

6.2.2 Pursuit of Affordable World Class Quality and Standards of Care

Although the country has already reached a reasonable level of healthcare provision, there is a need to ensure that the standard of practice of medicine is maintained and at par with international standards. The importance of quality and standard of care will remain unchanged whatever the choices of mechanisms in health policy. Quality and innovation will attract inward investment and generate income to the nation through many opportunities in the health sector and industry e.g. health tourism, but pose challenges in marketing and branding.

6.2.3 Inappropriate Utilization

All Malaysians are provided access to healthcare, which covers a wide array of services. With the increasing demands and expectations of the public, those who can afford could by-pass primary care to obtain more costly services directly from secondary care.

The government places few controls over the supply of care. General practitioners may practice wherever they choose, in any area of medicine, and are reimbursed on a fee-for-service basis. Nevertheless, the Private Health Facilities and Services Act 1998 (PHFSA 1998)/Regulation 2006 provide some control over the country's private hospitals.

6.3 RISING COST OF CARE

As the population increases, the number of admissions and number of outpatient visits will increase. This means there is more demand for services and the cost of healthcare will increase. It is estimated that annually there is a 3% increase in admissions to MOH hospitals.

The use of ICT, new technology and new interventions have shown to improve delivery of care but these come with a cost which includes user training, maintenance, infrastructure redesign and renovation, more diagnostic investigations and perhaps new consumables and reagents. New modalities of care are more intensive and require more specialized facilities like operation theatres,

more endoscopic suites and intensive care beds. Extensive research and development (R&D) has produced new costly drugs which are more effective and has fewer side effects. The demand for these drugs will also increase from well-informed patients.

Migrant workers also add costs to healthcare as they bring to this country various re-emerging infectious diseases that require proper control and treatment. Commercialization of healthcare as marketed by many private laboratories also increases inappropriate diagnostic investigations.

Financial constraints facing the country right now has gradually shifted more patients to the public healthcare system. Other than adding more financial burden for the government, primary care services currently are finding difficulty in ensuring appropriate contact time between doctors and patients because of the high workload. Unless more resources are obtained, quality of care and responsiveness will be affected.

6.3.1 Inefficiency

The existing healthcare delivery system has been far from efficient and that there has been tremendous wastage of resources within the public and private sector. The existence of the dual system of care contributes to the misdistributions of resources. This has led to duplication of services and to a certain extent, underutilization of high end expensive technology. All this leads to waste and economic inefficiency. There were reports stating that some hospitals in the public sector had low bed occupancy ratio. There were also reports of underutilized and unused high end equipment when skilled specialists resigned from the public sector.

6.3.2 Increasing Demand for Health Services in Institutions

There is an increase in demand for MOH to provide health services to the population or inmates of residential institutions such as National Service Training Camps (PLKN), Prisons, Polytechnic Colleges, Sports Schools, Narcotic Addiction Rehabilitation Centre (PUSPEN), Welfare Institutions and Detention Centre for illegal immigrants.

Reports on several outbreaks such as Influenza-Like Illnesses, food poisoning and death in institutions have raised public concerns. The health of the inmates in detention centres was seen as important areas in addressing equity and accessibility.

The Ministry of Health has been providing services to the respective institutions through mobile teams or staff deployment. For PLKN camps, Ministry of Health started giving support by placing Assistant Medical Officers and Nurses to the camps on rotation.

6.3.3 Wasted resources

Research has shown that the primary drivers for waste are lack of clinical quality, inadequate and incompetent workforce, poor patient flow, poor supply chain and the presence of mismatched services. For e.g. many healthcare processes are wasteful for both patients and staff. If there is better coordinating care and prevention of adverse events and complications (like hospital acquired infection, readmissions after 24 post discharge and post operative bleeding) savings can be realized. By redesigning and enhancing patient flow through inpatient and outpatient services, the throughput can be maximized to meet demand. Delayed access bears cost as there is a risk that patients will arrive with more complicated clinical conditions requiring more specialized forms of treatment.

6.4 COST DRIVERS

The four main factors driving rising costs are wealth, lifestyles, technology, and longevity. With regards to healthcare consumers - wealth, social norms and lifestyles determine expectations, hence needs, wants and demands.

6.4.1 Wealth

The country's growing wealth encourages people to seek more care. This is evident in per capita spending on healthcare that correlates significantly with the Gross Domestic Product (GDP). In this sense, wealth or GDP growth is the engine that determines the bulk of the change in healthcare spending. GDP with the other factors i.e. lifestyles, technology, longevity determines the healthcare spending curve relative to GDP. In 1997, Malaysia's GDP for health was 2.9% GDP and it has grown to 4.7% in 2007, but this is still low spending compared to what is expected for Malaysia, an upper middle income nation.

6.4.2 Epidemiological transition

Like all developing countries, disease patterns in Malaysia are in epidemiological transition. Major health problems have changed from that of acute infectious diseases to chronic lifestyle related disorders like cardiovascular diseases, diabetes mellitus, cancers and age related disorders. Conditions related to external causes such as injuries due to motor-vehicle accidents are also major causes of morbidity and mortality. Accidents, cardiovascular diseases and cancer are now major causes of admissions to MOH hospitals ranking 3rd, 5th and 10th respectively in 2008. In 1997, 37,398 cases of various types of malignant neoplasm cases were admitted to MOH hospitals. Ten years later, the cases nearly doubled to 59,697 cases. Concurrently, cardiovascular diseases, accidents, and cancer are major causes of death ranking 1st, 3rd and 7th respectively. Health services will also have to deal with a new generation of rapidly emerging problems that includes environmental pollution, emerging and reemerging infections plus social and behavioural problems.

During previous plans many types of services were developed to meet the needs of patients with chronic diseases. Generally these services result in more intensive patient care and improved patient outcomes. Although there is significant improvements in survival rates for example in strokes cases, injury resulting from accidents have not been showing much improvement in terms of reducing mortality. Patients with complex and ongoing conditions place an additional demand on hospitals and clinics. Services will need to respond to not only life saving acute care but with care that addresses behavioural risk factors and other chronic health factors through early intervention, self management, partnerships with other service providers and care support.

The shifting treatment patterns required by changes in the prevalence of different diseases especially chronic diseases will also drive costs up. For a long time, the population and disease transition creates demand partly a result of factors outside the system's control, such as the population's lifestyle and diet. Yet rates of obesity and diabetes are increasing as people eat more unhealthy food and do not adhere to healthy lifestyle practices.

The changing needs require that the health sector diversify - adding and strengthening relevant new activities and services - especially for those disadvantaged group and to ensure effective implementation. On one hand, we have to provide services to meet typical problems of developing countries such as infectious disease. On the other, we need to focus on the burden of diseases, risks and premature deaths associated with lifestyle and affluence such as cardiovascular, cerebrovascular, hypertension, diabetes, mental illness, substance abuse, accidents as well as illnesses related to industrialization, urbanization and environmental pollution.

6.4.3 Facing Emerging /re-emerging infectious diseases

The rapid population growth, increased economic activity and increased migration have been seen to give rise to a variety of emergent infections. These threats are a serious concern in Malaysia as evidenced by the recent H1N1 outbreak. In addition, the threat of re-emerging infectious diseases is a major concern. Dengue epidemics are now becoming more frequent, drug resistant tuberculosis and Malaria are on the increase and HIV/AIDS are showing a rapid rise. For emerging diseases, strategies to strengthen the ability to detect new syndromes or new patterns of disease must be in place.

Monitoring such clinical manifestations and epidemics will induce early detection of new pathogens and allow the development of treatment and prevention modalities. There is also a need to strengthen the surveillance systems for re-emerging infections. All this require a certain degree of responsiveness on MOH. Steps must be taken to ensure that the right infrastructure like isolation rooms, fever clinics in the Emergency Department, Personal Protective Equipment (PPE) and stock pile of appropriate drugs and consumables are made available. Most importantly, standard guidelines and protocols are made known to the workforce. Regular training for the workforce is another important step in ensuring preparedness.

6.4.4 Demographic transition

The system is being further strained by a rapidly ageing population, many with multiple and chronic illnesses. It is estimated that the total population of elderly in 2020 will be 3.4 million compared to 1.4 million in 2000.

Older people use health services far more than younger people as they have higher prevalence of chronic diseases. Five most common morbidities among them are hypertension, diabetes, problems related to joints, respiratory system and eye problem (National Health and Morbidity Survey II (NHMS II) 1996). However, the NHMS III showed the disease pattern among the elderly had changed from diseases associated with ageing (as in NHMS II) to disease associated with life style i.e. hypertension, hypercholesterolemia, diabetes mellitus and adult asthma.

Overall MOH hospital admissions for elderly people totaled more than 400,000 in 2008 or 20.3% of total admissions. Compared to 2005, the percentage of elderly people being admitted has increased (Table 3). The demand for medical services will exceed the rate of population growth, as the aged population is expected to grow at a disproportionate rate. This is expected to consume a large proportion of funds for health where it is estimated that about 30% to 60% of total health care cost will go towards the elderly.

Table 3: Trend of hospital admission of elderly people, MOH Hospitals, 2005-2008

Year	Number of admissions for elderly people	% of total Hospital admission
2005	338, 469	18.57
2006	358,828	19.10
2008	418,181	20.37

Source : Health Informatics Centre, MOH (2008)

One of the biggest challenge will be how best to prevent and postpone diseases and disability and to maintain the health, independence and mobility of an ageing population.

Many of the chronic conditions of old age can be successfully detected; prevented and treated given sufficient resources and access to care. More long term nursing homes or institutional care needs to be planned and developed. To ensure universal health for all, services need to be extended and expanded, with implications on money, manpower, training and infrastructure.

In addition, another major concern would be the health of the adult population in the working age group that would need to support growing numbers of dependents. By 2020, the proportion of the working age group between 20-64 years old is expected to be 60%. Thus, health of this group is important as causes of deaths for this group are mostly preventable.

6.4.5 Technology

Furthermore, advances in technology and new medical treatments, procedures, and products are increasing the cost of care, and the existing financing mechanisms system will not be sustainable. Malaysia can do little to influence some of these factors e.g. it cannot prevent population ageing, and delays in the introduction of new technologies would be both medically unwise and politically unpopular. Unless the current financing mechanisms change, the system will be able to generate no more and leave a funding gap. With due consideration, it can also be concluded that healthcare resources are used largely by hospitals to solve problems that could be dealt with outside of hospitals – such as ambulatory and primary health care settings, health risk management and preventive measures, health promotion and environmental control (MNHA: 1997-2006).

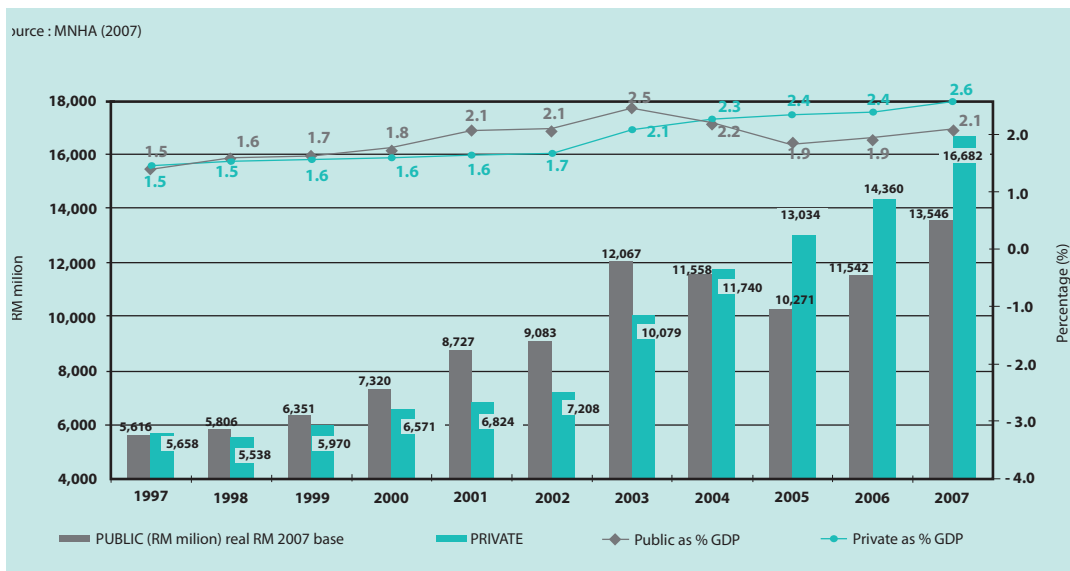
Although technology reduces some healthcare costs, it also expands the range of possibilities, as research shifts from preventive to curative and to incremental applications. Since technology creates supply (and demand, in systems where healthcare is subsidized), it drives up costs and this is not always in proportion to the improvement in care that a given technology aims to deliver. Inevitably, the progress of technology will raise the cost of health care. However, the benefits will increase exponentially as technologies become cheaper, faster, mobile and more featured. The medical fraternity is apprehensive of the tendency by medical providers to be inappropriately technologically-driven rather than patient-centered.

6.5 FINANCING THE SYSTEM

Just like many other developing countries, Malaysia is facing a serious challenge in how to finance rising demand for health services as the health system becomes more expensive. The past and projected total expenditure for health shows escalation driven by advancements in medicine and health technology. In the current healthcare landscape, the present financing arrangement where the government shoulders a substantial portion of the cost through general revenue (45% in 2007) may not be sustainable in the long term. MOH expenditure both in real and nominal terms has increased steadily though as a percentage of total government spending it has remained steady.

Healthcare expenditure has increased since independence. Expenditure trend from 1997 to 2007 is shown in figure 6.

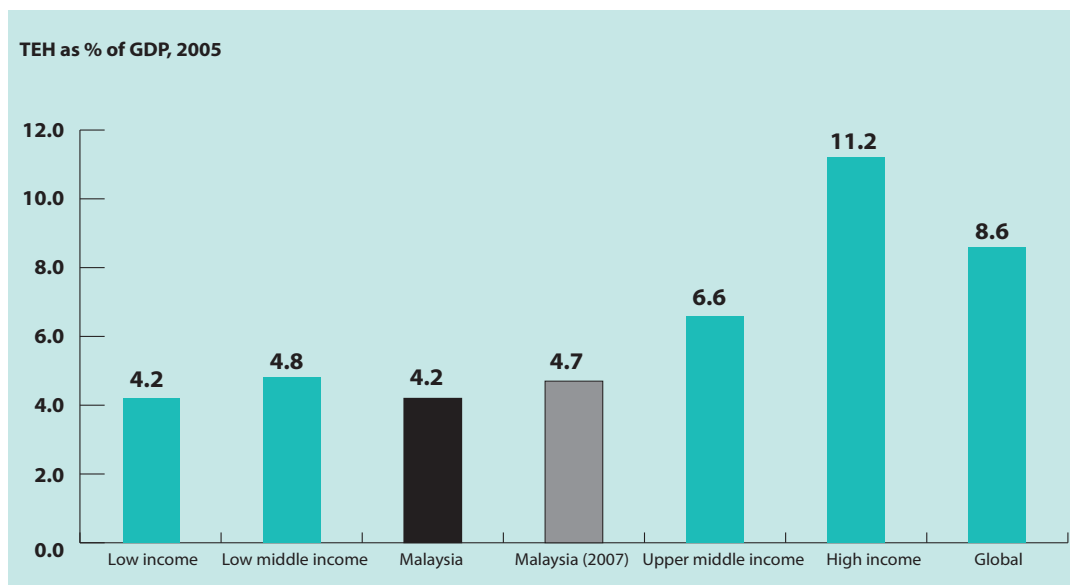
Figure 6: Public Private Expenditure on Health, 1997 – 2007 (2007 RM Value)



Source : Malaysia National Health Accounts 2007

However, as a percentage of GDP, it is only 4.2% in 2005 and 4.7% in 2007, which is lower than that for a lower middle income country (Figure 7). Public spending in 2007 accounts for 2.1% of GDP⁸. Initially public spending was higher in public than in the private sector. Since 2004, this ratio has reversed. In 2007, public spending was 13.5 billion and private spending 16.7 billion. The rise in private spending is associated with the rapid growth of the private health insurance industry during the same period.

Figure 7: Total Expenditure on Health (TEH) as Percentage of GDP (2005)



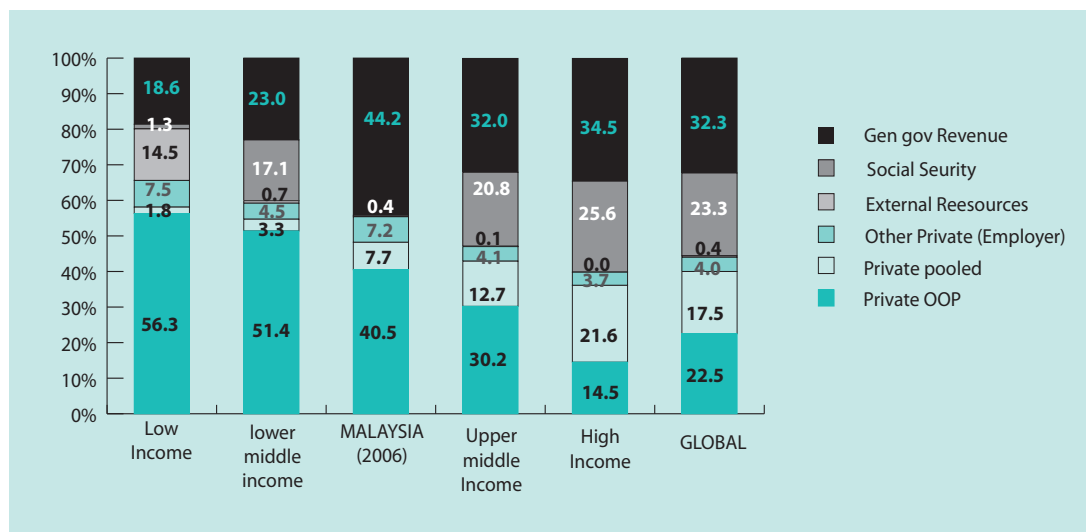
Source : Malaysia National Health Accounts 2007

⁸Global data suggest that the levels of catastrophic and impoverishment are low when there is general government spending on health at levels of 5%-6% of GDP. Higher government spending generally provides adequate public infrastructure and health service delivery at subsidized cost. (Health Financing Strategy for the Asia Pacific Region (2010-2015) WHO)

However, at the same time recent studies have shown that out of pocket payment has increased from 32% in 2001 to 40% (RM10.05 billion) in 2006. The 2006 National Health Accounts report indicates a high out-of-pocket (OOP) expenditure (Figure 8) i.e. 40% of total health expenditure; 73% of private health expenditure in 2006. A high OOP expenditure is reflective of a lower income country. Malaysia is in the upper middle income country group. As Malaysia has achieved universal coverage and the population is protected from catastrophic healthcare spending, the high OOP in the private sector reflects choice and preference of the payers. This is an indication of cost sharing by those who can afford. However, there is a need to harness this high OOP spending and ensure that it is spent efficiently and cost-effectively. Equally important is the need to ensure fairness in financing and continuing protection of the disadvantaged and vulnerable through a more comprehensive safety net.

It will be difficult to meet this pressure by solely continuing existing policies. Malaysia needs to implement additional measures like introducing more public involvement and contributions towards own health, as well as rewards and disincentives to prevent wasteful spending without undermining universal coverage. However, despite universal coverage, the World Health Survey Report (2002) shows that 4% of Malaysian households were exposed to catastrophic spending and 2% were impoverished. Furthermore, the household expenditure survey (2004) indicates that the lowest deciles (poorest) spends higher OOP than 8th deciles in terms of proportion to income. Hence, there is a need to ensure fairness in financing and continuing protection of the disadvantaged and vulnerable through a more comprehensive safety net.

Figure 8: Ratio of Out-of-Pocket (OOP), Public & Private Expenditures



Source : World Bank, 2005

In the current healthcare landscape, the present financing arrangement where the government shoulders substantial portion of the cost through general revenue (45% in 2007) may not be sustainable in the long term. MOH expenditure both in real and nominal terms has increased steadily though as a percentage of total government spending it has remained steady. However, at the same time recent studies have shown that out of pocket payment has increased from 32% in 2001 to 40% (RM10.05 billion) in 2006, reflecting a gradual shift from an upper middle income nation profile to that of a lower middle income nation.

6.5.1 Financial Crisis

In addition, Malaysia is not spared from the current global financial crisis as well as emerging social and political issues and challenges. It is also now witnessing a rapid pace of internationalization of service, setting the stage for new economic relationships. Increased investment, financial and information flows are fuelling the process of integration both domestic and international markets. The Malaysian health services will have to respond by rapidly adjusting to demands for greater competitiveness, efficiency and productivity improvements.

6.6 HEALTH AWARENESS & HEALTHY LIFESTYLE

Despite the achievements, more needs to be done. A number of challenges have been identified. These challenges form the basis for new areas of concern to be addressed in 10MP.

6.6.1 Knowledge-Behaviour Gap

There is still a wide gap between community's knowledge and their behaviour. Ultimately it is communities, families and individuals who must change their behaviour in order to be healthier. This calls for an effective and coordinated long-term public education campaign. Due attention needs to be given to the packaging of the campaign. It should incorporate evidence-based media advertising and targeted education for priority community groups. Campaign messages need to be integrated into activities within the community settings in order to establish healthy social norms.

6.6.2 Community's Reluctance to Take Ownership of Health Issues

The community still does not take ownership of their health issues. Community empowerment thus becomes instrumental. Community needs to participate for their own health benefits. Their participation can be improved through developing their skills and abilities to build capacity. The health workforce needs to engage the community to help them to identify and ultimately overcome any barriers or impediments to sustaining health and preventing illness.

6.6.3 Insufficient Number of Health Promotion Workforce

The potential for community behaviour change is greatest at the operational level of health promotion service delivery. There is an urgent need to establish Health Education Unit at every health district office, clinic and hospital. At the moment only 29 out of a total of 108 district health offices have such units. Only 43 out of 136 hospitals have the unit established. Establishment of such units with sufficient resources would ensure effective and efficient delivery of health promotion services.

6.6.4 Lack of supportive environment

Obesity has been on rise. The fast food culture is growing with easily available fast food outlets compounded by aggressive advertising promotions. In addition, the community is becoming increasingly more sedentary.

There is lack of supportive environment to encourage people to be physically active. Limited, poorly maintained recreational facilities and unsafe environment have contributed to sedentary lifestyle. Smoking in public not only affects the health of smokers but also the surrounding people. There is a need to bring the silent majority to voice their rights for a smoke free environment.

6.7 EMPOWERMENT OF INDIVIDUALS AND COMMUNITIES

6.7.1 Constraints in Implementing Healthy Public Policy

The main aim of implementing a healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible or easier for the individuals and communities. We need to invest resources in healthy public policy and health promotion in order

to raise the health status of all. As such, laws, regulations and enforcement activities are the tools to facilitate and enhance individuals and communities for self empowerment.

6.7.2 Weakness of legislation and enforcement

Enforcement activities are at times difficult to be carried out due to the constraints and obstacles faced by the personnel. Lack of human resource, the necessary skills and professionalism in enforcement as well as lack of monitoring worsens the condition.

Awareness and social responsibilities by tobacco manufacturers and retailers in following the rules and regulations is very low as they are profit orientated businesses. As an example, the selling of cigarette cases within the same premise for the purpose of replacing cigarettes package has hampered the process of educating smokers. The assessment on the health warning pictorials should be monitored to ensure the effectiveness of this legislation and avoiding abuse.

To ensure the success of campaigns such as the "Tak Nak Merokok", commitment from other Agencies and Ministries is a must, not solely from MOH itself. Availability of smuggled cigarettes sold at cheaper prices has somewhat reduced the impact of the "Tak Nak" campaign. This is due to poor enforcement by relevant agencies. Community leaders must be good role models to assist in making this campaign a success.

Another example of weakness of legislation and enforcement is related to advertisement of health products. Some of the advertisements about health products in the mass media may give false claims, which could influence the public negatively in making good health decisions.

6.7.3 Conflicting Policies

Many policies of other Ministries may not be in-line with the MOH. While Malaysia is encouraging tourism via having Malaysia Food Festival, this is against the MOH's healthy eating initiative under the Healthy Lifestyle Campaign and the Healthy Menu. Likewise, the existence of many fast food restaurants which provides high calorie, high fat content food is definitely not in line with MOH's healthy eating campaign. By controlling the price of sugar, the public will be encouraged to increase the usage of sugar.

6.7.4 Lack of Public Awareness

There is a need to create a high level of awareness within the public about health and wellness, for example: awareness on health risk assessment, prevention of disabilities and healthy ageing. In Malaysia, non communicable diseases surpass the communicable diseases in terms of morbidity and mortality. Non-Communicable Disease (NCD) such as cardiovascular disease, diabetes and cancer are the major causes of admissions and deaths in government hospitals (source - IDS Unit). The National Health Morbidity Surveys (NHMS) conducted in 1996 (NHMS II) and 2006 (NHMS III) showed that the prevalence of diabetes and hypertension are increasing in trend. The prevalence of Diabetes Mellitus has increased twofold in NHMS III (14.6%) as compared to NHMS II (8.3%) and higher prevalence in Hypertension and Cardiovascular Disease has also been observed in NHMS III.

The prevalence of physical disability has doubled over the period of 10 years from 3.2 per 1000 (NHMS II, 1996) to 6.3 per 1000 (NHMS III, 2006). About 40% of new diabetics seen at MOH eye clinics are legally blind, 30% have low vision and 9% totally blind (2007 Diabetic Eye Registry Report).

By the year 2020, it is estimated that people of 60 years of age will contribute to 11.2% of the total population, with a consequent increase in morbidity (NHMS III, 2006). The expected increase in the number of elderly will result in a consequent increase in morbidity conditions which may consume a large portion of funds for health. It is difficult to change and modify behaviours of individuals and communities. A lot of health messages and information has been disseminated to the public but these have yet to be translated into actions and behavioural changes. Other determinants of health such as socio-economic, environmental and political factors are also important for behavioural change.

Individuals must be encouraged to have at least an annual medical checkup and screening of risk factors, for early detection of diseases. Although the policy of routine medical examinations for government servants above the age of 40 has been introduced, some of them have yet to get themselves examined. Similar situation was observed amongst MOH personnel who are above 40 years of age.

Many consumers are also not aware of the nutritional contents of goods they purchase as observed in the findings of NHMS III, (19.3% do not read nutrition labels). They will buy products not because of the content but may probably have been influenced by friends or through advertisements. Consumers are also not aware of their right to adequate medicine labelling as required in Regulation 12 in the Poison Regulation 1952. In a National Survey on the Use of Medicines (NSUM) by Malaysian Consumers in 2008 revealed that 55.6% did not understand the proper use of their medicines, 51% did not recognize the trade name of their medicines, and 65.7% did not recognize their medicines' generic names and 26% of consumers had difficulties in reading labels on the medicines. Based on these findings, there is a dire need for an effective educational intervention targeting consumers in order to empower them with pertinent information on the medicine use.

6.7.5 Weaknesses in Programme Implementation

Although there are many achievements in the programmes initiated by the MOH, there are still weaknesses in its implementation. For example: it has been observed that not all health clinics and hospitals fully implement the Baby Friendly policy. Baby friendly clinic and Baby friendly hospital policies were made to facilitate and encourage mothers to breastfeed their babies. Supervisory role by Matrons and Sisters are important in order to sustain the implementation of these policies.

Success of programme implementation is highly dependent on training the adequate number of staff. Failure in training adequate number of people will affect the success of the programme. This can be seen by the poor achievement of the Quit Smoking clinic, wellness clinic, etc.

Prevalence of Breast Self Examination was higher in NHMSIII (57.6%) as compared to NHMSII (34.2%). Prevalence of married women that has ever had a pap smear done in NHMSIII has increased by 20%.

HIV screening and testing policies are made available within the facilities of the MOH. (e.g. Screening of antenatal mothers). HIV screening is however still on a voluntary basis. Furthermore, there are screening policies that involve other agencies and as such interagency agreement must be put in place.

The MOH has a number of programmes designed to empower specific groups within the communities for example the Young Doctor Program and Healthy Programme Without AIDS for Youth / 'Program Sihat Tanpa AIDS Remaja' (PROSTAR). The effectiveness of these programmes will depend, to some extent, on the receptiveness of the other participating agencies, for example the Ministry of Education.

6.7.6 Constraints Empowering Women & Specific Risk Groups

- Empowering women

Women are the 'primary health promoters' all over the world. For their effective participation in health promotion, women require access to information, networks and funds. All women, especially those from ethnic, indigenous, and minority groups, have the right to determine their health, and should be full partners in the formulation of healthy public policies to ensure gender appropriateness.

Although women in Malaysia have achieved a high level of academic, social and economic status, gender biases still exists within the community especially in rural areas. This affects their ability to make decisions in terms of self care in health.

Other factors that form challenges to empower women in Pap Smear and breast self examination include:

- i. Breast Self Examination (BSE) and Pap Smear examination is still a taboo to be discussed openly within the community especially amongst the Malays in some rural areas. Some of the community nurses posted to the community clinic (Klinik Desa) are very young still single and are therefore embarrassed to discuss these matters.
- ii. Community nurses are not allowed to do Pap Smear and must be trained before being allowed doing so.
- iii. Campaigns via mass media not reaching the marginalized group.

Involvements from the NGOs are mostly concentrated in towns and big cities.

- Empowering specific risk groups

Some specific risk groups which need attention are female sex workers and spouses or partners of drug users. More often than not, these groups are usually substance abuser themselves and they are at risk of contracting HIV and other sexual transmitted infections. They usually do not come forward especially to government facilities for treatment, care and other services. At the same time they also need to be empowered to prevent subsequent negative health implications.

Empowerment by imparting knowledge of the dangers of drug abuse, infectious diseases, opportunity for rehabilitation, knowledge on legal and social rights and also employment opportunities could help them to lead a better life. Some activities especially involving their peer groups are best done by NGOs in collaboration with government agencies.

The lack of knowledge and ability to care for persons with disabilities puts a strain on both the person with disability as well as the family. The study on physical disability alone in NHMS III (2006) showed that more than 60% of persons with physical disability required assistance from a caregiver. The health of caregiver is affected depending on the mental and functional status of the individual with physical disability.

Caregiver's health is also affected depending on the types of care required. For example, the prevalence of low back pain is higher in caregivers of children needing assistance with transfers. The higher the level of care provided the more negative impact it has on the caregiver's physical and mental health and their social and economic opportunities. Persons with disabilities and their families have to be provided with enough information and skills to maintain and enhance health status of both the patient and the caregiver.

Similarly, maintaining the health of the elderly through community empowerment i.e. empowering the healthy elderly population to be responsible for the less healthy elderly population is an appropriate strategy. Currently the number of NGOs with interest in elderly care is still small. The 'Kelab Warga Emas' at the health clinics are potential entry points. In 2008, there are 225 'Kelab Warga Emas' throughout Health Centres in Malaysia.

6.7.7 Supportive Environment

Although the government plays an important role in health, corporate, business entities, non-governmental bodies and community organizations also have a role in health. Their potential for preserving and promoting people's health should be encouraged. Trade unions, commerce and industry, academic associations and religious leaders have many opportunities to act in the health interests of the whole community.

In Malaysia there is still a lack of supporting health programmes from NGOs and from within the communities. There are NGOs involved in certain health programmes, such as the prevention of HIV/AIDS by Malaysia AIDS Council, early detection and prevention of cancer by National Cancer Council (MAKNA) amongst others. Social mobilization/ community participation is an important element in any health empowerment with the support of NGOs and communities.

Certain programs have been implemented with the support of the community, e.g.: Communication of Behavioural Impact (COMBI) in communities participating in the control of Dengue. The approach has shown successes in decreasing the number of dengue cases. However the sustainability of the project is still a problem due to many factors such as human resource, fund and self empowerment.

There exist within the Ministry of Health two volunteer bodies i.e. the Advisory Panel in Health Clinics and Hospital Visitors Board. These two bodies act as a bridge between the community and the hospitals and clinics, thus supporting the empowerment of the communities in self care.

6.7.8 Lack of Resources

Resources such as human resource, material and funds are important to initiate and sustain health program and activities within the communities. Providing adequate and trained health educators at community level are also important.

6.7.9 Organizational issues.

Currently, the two main players looking into community empowerment is the Health Education Division from MOH and the newly formed Malaysia Health Promotion Board. It is important that programmes and activities be monitored and evaluated for the benefit of the population by these main players.

6.8 INFORMATION COMMUNICATION TECHNOLOGY (ICT)

Telehealth brings new challenges, expectations and demands from an information-seeking and knowledge-based society.

6.8.1 Inadequate integrated planning of health information systems

Programmes stood independently of others without taking into consideration integration across the healthcare enterprise:

- Standalone and different information systems at health facilities (both hospitals and clinics). The Lifetime Health Record (LHR) project that was planned to integrate the various information systems has been postponed indefinitely.
- Adaptation of end-users to the new work processes
- Lack of uniformity in operational policies of the hospitals
- Absence of policy and facility to empower access to secured personal health information

6.8.2 Health Informatics Expertise (Subject matter experts and technical experts)

- Lack of local subject matter experts to implement projects
- Lack of capability and capacity in managing health IT operations and maintenance
- Lack of enforcement of IT policies – adherence to the policies

6.8.3 Infrastructure

- Huge financial resource requirement (capital expenditures and maintenance expenditures) for system sustainability and roll-out

6.8.4 Standards

- Lack of development and adoption of Malaysian health informatics standards that cater to local needs.

6.9 RESEARCH

The shortcomings described earlier have resulted in the low yield of quality research outputs including commercialized products. The main challenge as also seen in other parts of the world is the failure to create sufficient critical mass of skilled researchers. It has been a perennial problem to recruit, attract and sustain the best researchers. Amongst the existing researchers, many have yet to reach a satisfactory level of expertise. At the same time, expertise in newer areas such as health economics, policy analysis and more medically oriented areas such as genomics and other molecular fields are lacking. Many reasons have been identified and these include:

- Lack of career pathways and performance incentives
- Inadequate infrastructure including IT support to undertake more sophisticated research and
- Limited access to relevant databases and journals to support research.

From a systems perspective, there is a need to further strengthen the national health research system which includes:

- Better governance including compliance to research ethics and accountability
- Defining research priority areas that will be relevant to 10MP
- Ensuring continued optimal resource allocations
- Better monitoring, tracking and evaluation of research projects and outcomes.

In addition, for research to be beneficial towards achieving the MOH's and country's goals there is a need to improve the uptake of research evidence for decision-making and policy formulation. To improve the quality of research products, there is a need for research institutions to identify well known and credible international organizations for purposes of collaboration and benchmarking.

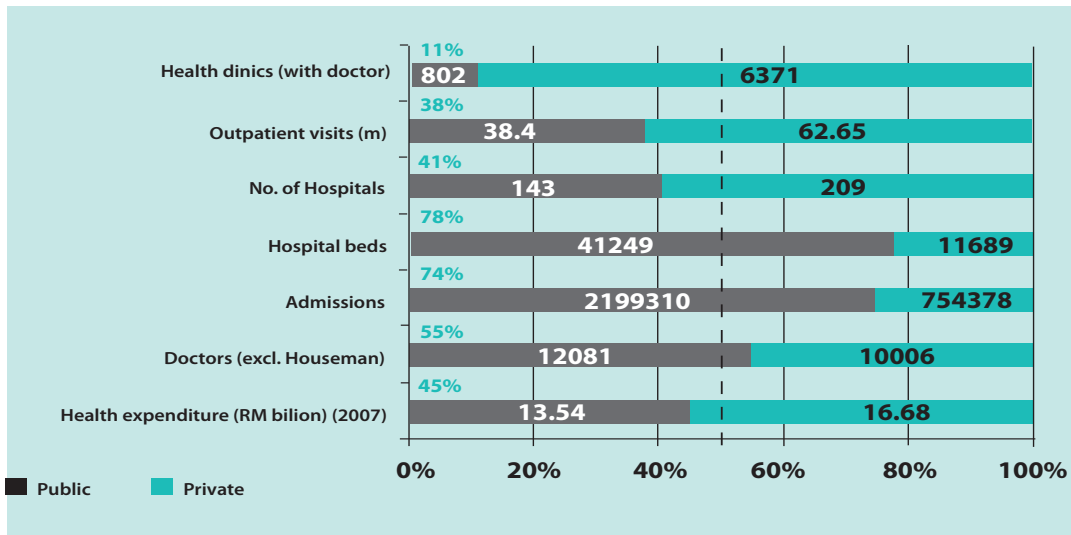
6.10 HUMAN CAPITAL DEVELOPMENT

Human capital is a critical resource and success factor for the health sector in Malaysia to make a successful quantum shift to the future. Enhancement of human capital was a major focus during 9MP, however, adequate workforce with the right mix of numbers and skills remain elusive. The healthcare providers in Malaysia consist of multidisciplinary and multi-skilled health workers. For sustainable services, these workers must have various range and level of competencies with adequate numbers supplied. The latter is the most challenging criteria for Primary Health Care (PHC) services to ensure equity and accessibility to services.

For secondary and tertiary services, the rise of new technology and new type of care requires not only adequate numbers but to be competent with new technology and interventions. As care becomes more complex and intensive, the probability of making medical error is higher and competency of the workforce must be absolute. Efforts therefore must be maintained and strengthened to attract, train and retain skilled human capital to work before the sustainability of services is seriously challenged. For example, the doctor to population density of 1.0 per 1000 population and nurses

density of 1.35 per 1000 population are less than the current global rates (1.23 and 2.56 per 1000 population respectively - World Health Report 2007). 60% of the doctors are in the public sector but 60% of the specialists are in the private sector with the private sector having the significantly lesser workload per doctor (Figure 9).

Figure 9: Public and Private Sector Resources and Workload (2008)



Source : Health Informatics Centre, MOH

Shortages made worse by misdistributions of human resource have resulted in inequity and disparity. Competition in the labour market clearly favours the private and international sectors as the public sector cannot compete in terms of salaries and benefits offered. This is more acute in primary care and also certain tertiary sub-specialties in the public health system. There have been existing concerns on shortage of doctors in the public health sector, and imbalanced distribution in remote areas, certain states, some critical areas, and difficulty in placement and retention of doctors and nurses in these areas. Meanwhile, the growth of the private health care sector has triggered the migration of senior doctors, specialists and experienced allied health professionals from the public sector to the private sector. The challenge is to develop a national strategy on health workforce and strengthen effective coordination for human capital planning and development.

6.10.1 Mismatched supply and needs/demand

Malaysia does have a shortage of doctors (a rate of about 1:1000 people) relative to the global rate (1:800) and to other developed countries e.g. Japan has 1:500, whereas the Organization for Economic Co-operation Development (OECD) average is 1:350. Given the propensity of most doctors wanting to move into secondary and tertiary care specialties, eventually, the shortage is felt most acutely in the primary care particularly with low reimbursement rates or poor working conditions. The private sector combines an excess supply of some health resources with massive overutilization. On the other hand, the public health system combines shortages of health professionals made worse by misdistributions leading to, on average, a doctor in the public system having to see more workload.

Among the factors affecting healthcare service delivery is the attrition rate of personnel within MOH. Officers often resign from the Ministry due to lucrative offers from the private sector and overseas, the opportunity to join institutions of higher learning as trainers or the opportunity to operate their own clinics. Attrition among doctors and dentists in MOH is shown in Table 5.

Table 4: Attrition among Doctors and Dentists in MOH

Category	2005	2006	2007	2008
Doctors	401	248	300	478
Dentists	56	78	107	77
Total	457	326	407	555

Source : Human Resource Division MOH

6.11 NO EASY SOLUTIONS – THE CHALLENGE

Malaysia must find ways to increase the system's financing, cost efficiency, or both. Traditionally, the country has relied on government subsidies, out of pocket payments, employer payments and insurance premiums to finance health care. At some point, however, increasing the burden of these financing mechanisms will place too much strain on the nation's economy.

Malaysia need to further enhance its policy and regulatory roles over the whole system (public and private) to have better control over matters such as the allocation of medical resources, establish clear targets for providers, and mechanisms to force them to take a more coordinated approach to service delivery, jurisdiction over development of hospital and clinic development, the purchase of very expensive medical equipment in order to prevent or minimize its inappropriate or under utilization. The payments of providers need to cap the total amount paid, as most systems based on diagnosis-related groups (DRGs) do and must cover outpatients. Otherwise, hospitals and doctors still benefit financially by keeping patients in beds or provide unnecessary and lower quality services.

In the current economic climate, the choices are not attractive. Nevertheless, the country may need to consider the possibility of increasing healthcare funding to cover the rise in health care spending and ensure sustainability. Fee cuts do little to lower the demand for health care, and prices can fall only so far before products become unavailable and the quality of care suffers. In addition, a country that applies fee cuts across the board, a politically expedient approach, fails to account for the relative value of services delivered.

There are numerous challenges but the key ones are:

- Addressing rising healthcare cost and increasing resources towards a sustainable health system
- Meeting increasing needs, wants (and demands) due to increasing affluence (rapid economic growth) fuelling demand and rising public expectations
- Responding to changing demography, ageing and migration, disease burdens and transition
- Managing expensive, overutilization and underutilization of new technologies and medical advances
- Responding to variations in distribution of delivery (universal access, responsiveness) and quality and standards of care in health services
- Increasing capacity and redistributing of health workforce/health professionals
- Addressing tendency to deliver episodic and fragmented care as continuity of care is a major concern
- Enhancing integration of healthcare delivery using integrated health records and Telehealth/IT efforts
- Managing the public–private dichotomy
- Responding to increasing public scrutiny and demands for performance and accountability with regards to the above challenges

PART II

PART II

7. FRAMEWORK FOR 10MP AND THE FUTURE DIRECTIONS

Vision 2020 remains dear in the heart of every Malaysian. To achieve this, the Government of Malaysia has outlined 5 National Mission Thrusts (2006-2020) and targeted the annual GDP growth to be 5.5% yearly or more. However, the recent economic downturn affected the performance of most countries. Malaysia is no exception, with GDP growth on an average of 2.7 % during the 9MP period. As such, the 10MP has become a vital vehicle for Malaysia to adopt directions and strategies to ensure that national development effort is on the right tract/ trajectory to realise Vision 2020.

6 National Strategic Directions (SD) were identified:

- SD 1: Competitive Private Sector as Engine of Growth
- SD 2: Productivity & Innovation through K-economy
- SD 3: Creative & Innovative Human Capital with 21st Century Skills
- SD 4: Inclusiveness in Bridging Development Gap
- SD 5: Quality of Life of an Advanced Nation
- SD 6: Government as an Effective Facilitator

The private sector remains as the engine of growth with the government facilitating it. In the 10MP, the government has committed the development expenditure ceiling of RM180 billion as compared to RM230 billion during the 9MP. Out of RM180 billion, RM15 billion is for Private Funding Initiatives (PFI) Facilitation Fund. Another RM20 billion is to be obtained from private investment that is the PFI. The reduction in the direct development budget commitment from the Government would encourage the Nation to be more focussed on the provision of healthcare services efficiently rather than focussing purely in the development of health facilities. Innovative strategies are required to quantum leap towards achieving our Vision 2020.

7.1 NATIONAL DEVELOPMENT DIRECTION

The Planning and implementation of 10MP is pivotal on the philosophy of 1Malaysia: Rakyat Didahulukan, Pencapaian Diutamakan. This concept is the guiding thrust of the National Mission and the basis of the National Development Direction which consist of:

- 5 National Mission Thrusts
- 6 National Key Result Areas (NKRAs)

The 10MP, guided by the above, have come up with a socio-economic transformation package to manoeuvre the nation back to the Vision 2020 trajectory. The package consists of the following:

- 6 Strategic Directions to achieve a high income advanced economy
- 24 Key Result Areas (KRAs)

Each KRA is measured by outcome and KPIs that is the result of strategies adopted to achieve the results.

7.2 HEALTH SECTOR DEVELOPMENT DIRECTION

MOH being the lead agency will be responsible for formulating the strategic direction for health in relation to the National Missions Thrust. The MOH is also required to translate national development direction in terms of health development and propose its KRA, outcome and strategies based on

the relevant national missions thrust, strategic direction and 10MP KRA, outcomes and strategies.

- National Mission Thrust : To Improve the Standard and Sustainability of Quality of Life
- 10MP Strategic Direction : Quality of Life in an Advanced Nation
- 10MP Key Result Areas (KRAs) : Quality Healthcare & Active Healthy Lifestyle
- 10MP Outcomes : Ensure provision of and increase accessibility to quality health care and public recreational and sports facilities to support active healthy lifestyle

Although, the main focus of the health sector is for strategic direction 'Quality of Life of an Advanced Nation', the health sector has also some roles to play in the other strategic directions. Quality Healthcare & Active Healthy Lifestyle has been set as the main key result area (KRA) for the health sector for the 10MP period. The outcomes are to ensure provision of and increase accessibility to quality health care and public recreational and sports facilities to support active healthy lifestyle. Subsequently, four 10MP strategies were identified which are:

- Strategy 1: Establish a comprehensive healthcare system and recreational infrastructure
- Strategy 2: Encourage health awareness & healthy lifestyle activities
- Strategy 3: Empower the community to plan or implement individual wellness programme (responsible for own health)
- Strategy 4: Transform the health sector to increase the efficiency and effectiveness of the delivery system to ensure universal access

Based on these four strategies, MOH has identified KRAs, outcomes and broad strategies that need to be translated and reflected by MOH Programmes in terms of programme objectives and activities. Programmes Directors should note that the 10MP KRAs and outcomes should form the basis of the development and annual operating budget.

7.3 PROPOSED HEALTH SECTOR NATIONAL PROGRAMS FOR 10MP

Malaysia health services provision and delivery comprise of the public health services and medical services including oral health services. The delivery of services are supported by the Research and Technical Support (including Engineering); Management and Financing, and Pharmaceuticals as part of the health industry complex (include industries related to health human capital, facility, medical devices, Traditional and Complementary Medicine (TCM), pathology, wellness and more) that makes up a significant and potentially rapid growing portion of the nation's economy responding to the domestic and global needs, demands and expectations.

Malaysia's health system has made significant contributions in improving the status of health in the country. There has been declined of maternal mortality rate from 500 per 100,000 live births in the 1950's to 30 maternal deaths per 100,000 live births in 2008. The Millennium Development Goals(MDG) indicator 4, the under five mortality rate (U5MR) has declined from 16.6 per 1000 live births in 1990 to 7.6 per 1000 live births in 2006. Meanwhile the infant mortality rates (IMR) declined from 10.0 per 1000 live births in 1990 to 6.3 per 1000 live births in 2008. Furthermore average childhood immunizations coverage in Malaysia currently is more than 94%. Under the National Health Sector Development Program, the main functional programs that will play important roles in the setting and implementing the strategic direction and foci of the health sector during the 10MP are:

7.3.1 POPULATION HEALTH PROGRAM.

This program comprises of a Public Health-led population-based health services mainly focusing on health and wellness promotion and disease and illness prevention. Public Health had embraced virtually all aspects of social and economic policies, stressing on preventive measures against diseases, both on the part of the society, family and individual. Programs and activities in Public Health are inclusive of various strategies implemented by Disease Control Division, (which includes Occupational Safety & Health and environmental activities) Family Health Development Division, Food Safety & Quality Division, Health Education Division and Nutrition Division (new).

i. Healthy (and Active) Lifestyle Movements

The role of prevention and control of diseases in reducing morbidity and mortality have been the part and parcel of the Disease Control Division since independence. Non-communicable diseases (NCD) which include heart diseases, stroke, diabetes, cancer, mental illnesses and chronic respiratory diseases presents a huge challenge in the next few decades, globally as well as for Malaysia. The prevalence of NCD and NCD risk factors continue to rise rapidly in Malaysia. Statistic from the latest National Health and Morbidity survey in 2006 has shown a drastic increased in the prevalence of diabetes from 8.3% in 1986 to 14.9% in 2006 for Malaysian adults age 30 years and above. The same survey has also shown that the prevalence of obesity has increased from 4.4% in 1996 to 14.0% in 2006 for adult Malaysians aged 18 years and above.

ii. Nutrition Improvements

Nutrition Improvements is administered through four functional areas of nutrition planning and development, nutrition promotion, nutrition rehabilitation and nutrition surveillance. Activities under nutrition planning and development include planning, developing and evaluating nutrition programs and activities, and monitoring and evaluating the implementation of the National Plan of Action for Nutrition of Malaysia (NPANM) 2006-2015. Nutrition promotion encompasses promoting infant and young child nutrition, adolescent nutrition, nutrition in institutions and adult nutrition through healthy eating and nutrition for the elderly and those with special needs. Healthy eating is also propagated through the establishment of Nutrition Information Centers.

iii. Empowering Community, Family and Individuals.

Implementation of annual communication campaigns through mainstream mass media which include healthy eating, exercise and physical activity, no smoking, and stress management has gained ground and need to be further improved. The aims of these activities are to encourage health promoting practices and change of the behavioural lifestyles related to major population risk factors such as at home, schools, work place and other public places and activities. The notable encouraging outcome has been an increase in community awareness and knowledge on the respective risk factors as evident from post-campaign evaluation.

Health promotion is the process of enabling people to increase control over and to improve, their health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable individuals to achieve their fullest health potential. This includes creating a supportive environment, providing access to information and developing life skills and opportunities for making healthy choices.

iv. Communicable Disease Control (CDC), Crisis and Disaster Preparedness

The development of the prevention and control of communicable diseases in Malaysia has made a great progress in the past decade. The widening of the scope and changing disease pattern warrant us to revise our existing program and organisational structure. The lack of strong and coordinated linkages to the other relevant departments/ministries/organisations inevitably contributes to certain degree of weakness in the present systems and programs.

Even though the trend of communicable disease has shown the downward trend except for Tuberculosis (TB) and Dengue, monitoring and implementation of Communicable Disease Control Program is vital. It is to ensure that the incidence and prevalence of communicable diseases is continuously controlled, reduced, eliminated or eradicated.

v. Food Safety and Quality.

Under the 10MP, the Food Safety and Quality Division (FSQD) will face existing and new issues and challenges in food safety. The present trials and tribulation on the world with the emergence of new diseases and resistant strains posed unusual challenge to Malaysia's capability, capacity and preparedness plan for rapid action. The areas of concerns to be addressed in 10MP include Establishment of the Food Safety Authority (FSA), Strengthening Food Safety Control System, Strengthening Food Safety Surveillance, Strengthening Food Legislation, Strengthening International and Regional Trade Framework, and Strengthening Food Safety Education

vi. Community and Family Health development.

The unit of the population is the family. Ensuring accessible health services for each of the family member through a life course approach will facilitate the healthy development of each within the whole and hence the health of the Malaysian population. Provision of equitable distribution and universal access to quality family health services that is targeted at community-level interventions to nationwide universal programs, focusing on wellness, early identification and prevention, will be strengthened aiming at the reduction of morbidities and mortalities and hence well-being of the nation.

Healthy child through early stimulation will help with the country's agenda to achieve higher literacy and numeracy rate and facilitate early rehabilitation to those in need. Safe and reproductive health is the key to keep our adolescents and adults well prepared to lead a healthy and economically productive life, solid in preparation for the elderly years to come. The 'rights approach to health' will be given emphasis to ensure that gender equity and equality in health issue will be continuously addressed and the convention of rights of the child related to health will be pursued. The health of the disabled and the mentally challenged will find a secured place in the policies that the Ministry of Health will formulate henceforth.

7.3.2 PERSONAL HEALTH PROGRAM

This program comprises of a Primary Care-led personalized healthcare services mainly focusing on curative and rehabilitative services at primary, secondary and tertiary levels for those who fall ill. However, development needs to continue in specific discipline areas where there are identified needs and demands.

i. Integrated Primary Health Care (PHC)

The overwhelming attendances in the public health clinics in the last decade showed a healthy sign of the growing trust and acceptance of the public to the services that are being provided in the health clinics, despite the long hours of wait and stretched staff. The misdistributions of manpower which is lopsided favoring the private sector has been a long-drawn-out issue discussed which is now possibly seeing the light of day. The integration of the facilities in primary health care towards striving for universal access will be the key strategies that will be focused in this 10MP. The “comprehensive health primary health care scope of services be made available very accessible both in ‘time and space’ and equitable in both breadth and depth” is the vision that has been placed as the goal for this strategy. This calls for massive preparation in creating the solid platform for the smooth merging and assemblage of a pervasive network for care close to home.

ii. Secondary Care.

Lifestyle changes together with ageing population have now caused a rising level of illness and health risks where patients with complex and chronic conditions place an additional demand on hospitals. Secondary medical services need significant strengthening and expansion of 9 specialties comprising of internal medicine, surgery, obstetrics and gynecology, pediatrics, orthopedics, clinical pathology, anesthesiology, radiology and emergency medicine (includes pre-hospital care) to improve accessibility and quality of medical services. Strengthening of emergency services and pre-hospital care is crucial as conditions related to external causes such as injuries due to motor vehicle accidents are major causes of morbidity and mortality. In addition, the outbreak of infectious diseases such as SARS, H1N1 Virus and Nipah Virus over the last 2 decades have escalated the demand for emergency services and pre-hospital care.

Improvements in chronic care service like rehabilitation and palliative care for cancer and stroke patients will be aligned for better management of these patients to regain their health and functional living. To further reduce avoidable demand on costly hospital services and to continue improving health outcomes, these measures will need to be combined with strengthened ambulatory, community and home based interventions.

iii. Tertiary Care.

Subspecialties development will continue to be strengthened in regional hospitals in line with needs and demands as evident in the “Burden of Disease” study (2000) and the changing pattern of care from new technology and interventions. New technologies and interventions enable patients to receive more complex treatment that improve health outcomes. Areas for subspecialty development include expansion and strengthening of services related to heart diseases, stroke, cancer, and trauma. Some bottleneck specialties upon which other services are heavily dependent like anesthesiology, radiology, pathology and intensive care would also require very significant strengthening on site to support subspecialty services development.

7.3.3. RESEARCH & INNOVATION

This program is needed to enhance fast-paced innovations and productivity, and facilitate the service delivery of the above programs towards achieving the nation’s health system’s goals including efforts to control the rising health costs.

Health research is a critical means of empowerment, enabling nations and communities to understand their problems, decide on feasible actions, execute the actions efficiently and effectively and search for solutions to unresolved problems. In order to achieve excellence in research, it is important to attract and retain good researchers. Research should be perceived, not only as an important activity but also as an activity that is recognized by the government. All those involved in directing research, conducting research and implementing research should consider themselves as partners in ensuring a healthy nation.

7.3.4 HUMAN CAPITAL DEVELOPMENT FOR HEALTH SECTOR

This program is important as the health sector is labour intensive. Numerous categories of creative, productive and competent human capital is needed to ensure that the health service delivery effective and of quality as well meet the present needs and in line with the Vision for Health. Currently there is inadequate and misdistributions of human resource. These include doctors, dentists, pharmacists and other allied health professionals.

- i. At the same time, through improved PHC human capital for health and PHC facility development enhance the quality of health services delivered to the individuals in the family and community through individual, family, community/ population approaches to health services.
- ii. Focusing on specific disciplines identified in the Medical Program
- iii. Enhancing human capital development in research in order to build up capacity particularly in applied and/or commercializes research in emerging areas and of public interest

7.3.5 TECHNICAL AND OTHER SUPPORT PROGRAMS

Even though several technical support activities are placed in different organizations, these activities have the same aims - achieving the nation's health system's goals including efforts to control rising health costs. These include planning and development; quality and patient safety in healthcare; policy, regulations and enforcements; technology & ICT and Telehealth; engineering services as well as an Integrated Health Information System for planning, monitoring and evaluation.

Nevertheless, the health sector transformation agenda needs to encompass the whole industry, not just focusing on increasing resources, improving implementation and enhancing processes. The agenda also need to look into restructuring as an option including the health sector financing and to overcome structural issues in resolving among others the issues of public-private dichotomy, delivery responsiveness, sustainable financing, managerial effectiveness, decentralization and governance.

7.4 PROSPECTS & KEY RESULT AREAS

MOH, as the custodian for health for the nation, has been tasked to address the national mission thrust to improve the standard and sustainability of quality of life and contribute towards achieving the status of a high income economy. The contribution of the health sector is primarily through the governance and provision of services that will lead to improved health outcomes and ultimately to better health status befitting that of an advanced nation.

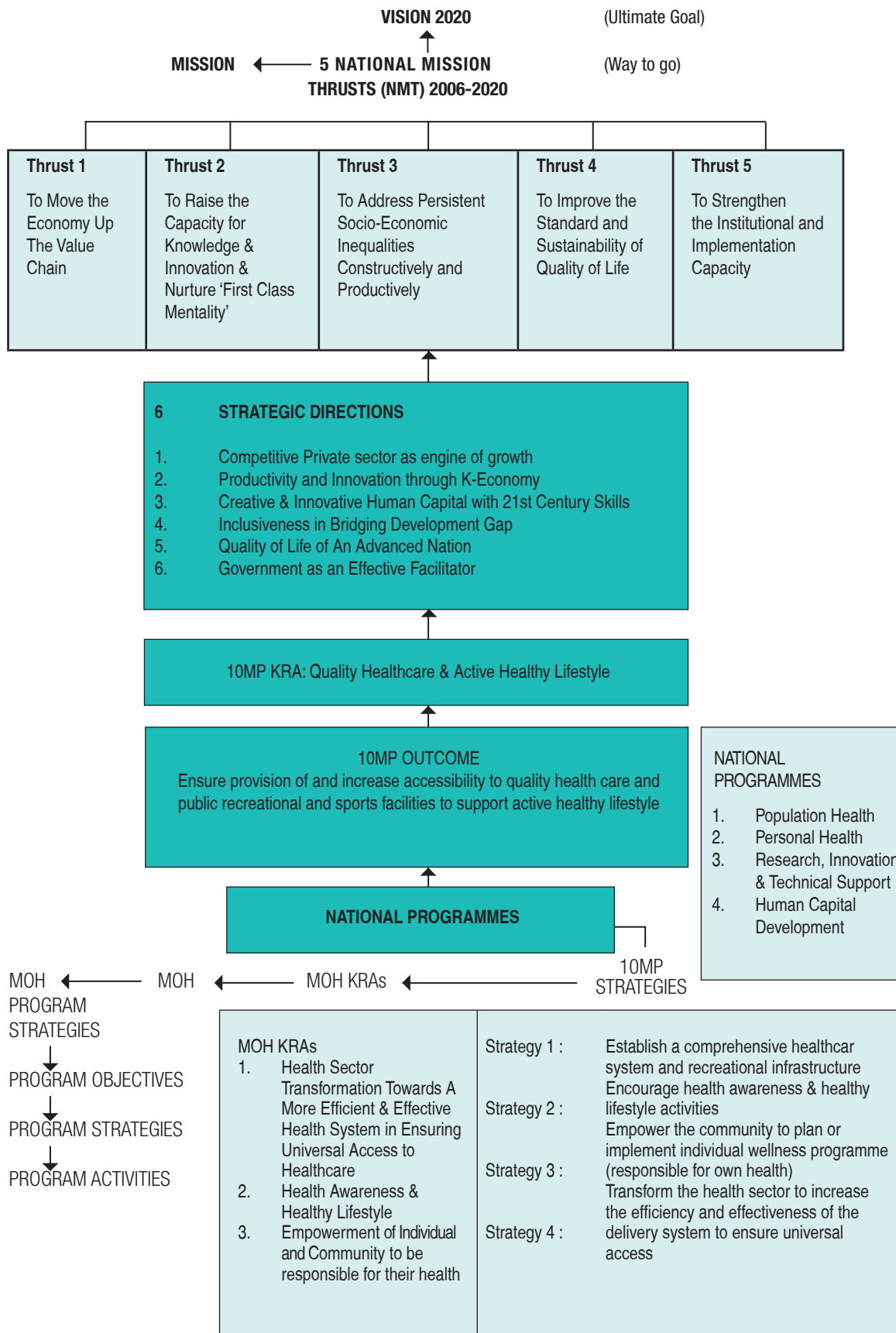
Three health sector development KRAs has been identified:

1. Health sector transformation towards a more efficient & effective health system in ensuring universal access to healthcare
2. Health awareness & healthy lifestyle
3. Empowerment of individual and community to be responsible for their health

A health system that is restructured in term of delivery and financing and complemented by good governance is expected to address most of the desired outcomes. An integrated delivery system where services can be obtained from both public and private sector would result in efficient resource use; improve access and better response from service providers. A quality assurance system that is institutionalized will ensure the effectiveness of care that is standardized with fewer variations. It should result in a more equitable distribution of facilities, in particular private enterprises to less developed areas. It is envisaged that public sector service will be more competitive and able to retain experienced staff

A restructured MOH will result in the devolution of service provision and supervision of professional standards to designated quasi-government bodies. MOH, through good governance and stewardship, will be responsible for policy, quality and safety, enactment, amendment and enforcement of laws. In order for MOH to deliver it needs a reliable information system to allow for integrated monitoring and evaluation. ICT will be strengthened as part of the exercise.

FIGURE 10: FLOW CHART ON THE 10MP PLANNING APPROACH



7.4.1. Health sector transformation towards a more efficient & effective health system in ensuring universal access to healthcare (KRA 1)

The proposed health financing mechanism, in particular provider-payment, should result in cost containment, reduction of out-of-pocket (OOP) spending and concomitant reduction in healthcare inflation. Eligibility of facilities to participate will be based on obtaining accreditation or International Organisation for Standardisation (ISO) certification. This will complement in-house quality assurance activities.

i. Expansion

Expansion of the health system is inevitable to ensure that equity and accessibility keeps improving. Since our Health for All indicators implies the maturity of the MOH and the Malaysian health sector, the net expansion would not be very much faster than population growth. However, additional costs/expenditures are required to cover the last portions of the population in remote areas - usually hardest logistically and most expensive per capita to provide services to i.e. costly to cover. In view of the changing needs and disease burden, the health system needs to diversify - adding and strengthening relevant new activities and services especially for those disadvantaged group - and ensure effective implementation. In addition, additional resource is required in providing better quality and patient safety, and standard of care towards a world class healthcare.

ii. Financing

To close the system's funding gap, Malaysia must consider novel approaches in health services delivery, financing and governance. There are no easy answers for any health system while the life and death nature of healthcare makes it difficult to justify tough economic decision making. If Malaysia, with all its unique features, can make progress in tackling its problems - financing, supply, needs and demand, and quality should pay careful attention both to the substance of its change agenda and to the way it navigates the uncertain waters ahead.

So Malaysia must act quickly to ensure that its health care system can be sustained. It must close the funding gap before it becomes irreconcilable, establish greater control over supply of services and demand for health care, and change incentives to ensure that they promote high-quality, cost-effective treatment. Many of the measures needed address a number of problems simultaneously and may prove instructive and fruitful towards a robust and resilient health system for Malaysia.

Another possibility is allowing payers to demand or making it mandatory for providers to give service mix, costs and outcome data and to adopt provider payment mechanisms encouraging cost effectiveness and better care. Another option is a payment scheme, so that individuals could influence the amount they spend on health care by making discretionary copayments or prepayments through insurance mechanisms. Such schemes capitalize on the fact some people are willing to pay significantly more for healthcare, usually for extras beyond basic coverage. Augmenting the current system with such approaches could reduce the funding gap.

iii. Incentives and Punishment

Malaysia can increase its power over the supply of health services in several ways. Incentives and penalties can reduce the number of hospitals and hospital beds where there are excesses. For example, offering financial incentives or penalties to encourage hospitals (especially subscale institutions) to merge or to abandon acute care and

instead become long-term, rehabilitative, or palliative-care providers. Similarly, monetary incentives and volume targets could encourage greater specialization to reduce the number of high-risk procedures undertaken at low volume centers. The country should also consider moving away from paying for primary care through uncontrolled fee for service payments e.g. capitation gives doctors a flat amount for each patient in their practice.

iv. Policies and Regulations

The demand side of Malaysia's health system invites greater intervention as well. Important first steps would include more strictly limiting services covered in order to eliminate medically unnecessary ones, as well as mandating flat fees based on patients' diagnoses (case-mix) to reduce the length of hospital stays. Another piece of the puzzle is to make practicing in primary care and other areas like emergency response, mental health more attractive for doctors and other health professionals; comparable or higher payment and compensation levels must figure in any solution. In addition, the health system probably needs to strengthen the regulatory bodies to oversee health facilities and require them to report regularly on treatments delivered and outcomes achieved, the other to oversee training programs for doctors and other health professionals and raise accreditation standards.

v. Integration and Sustainability

Transformation of the healthcare delivery system through changes in the health financing mechanism will ensure the integration of primary health care provision by public and private sectors with the aim to develop primary care provider as the gatekeeper to the more expensive hospital care. In addition, through integration there will be concerted efforts to optimize utilization of the limited resources, to ensure standardization of care and measurement of outcomes, enhance greater efficiencies through encouraging competitions between public and private sectors and ensure improved equity, accessibility and universality. Access to hospital services are mostly through the primary health care providers.

vi. Strengthening Services

- Primary Health Care

Primary Health Care will remain the Trust of Health Services. However, the ever growing scope and strain on the services coupled by the increasing expectations of the public, calls for greater attention for more adequate an appropriate supply of resources.

- Medical Services

Recognizing the changing pattern of diseases and the ageing population, the Medical Services can expect prevalence of conditions requiring ongoing and complex healthcare in 10MP. Clinical services need to be sustainable with availability of appropriate resources notably skilled workforce without which MOH might not be able to meet the demands for medical services. The sustainability of current services is seriously challenged by the skilled workforce shortages. Efforts to retain and attract people to work in MOH should remain a priority during 10MP to ensure services will be delivered equitably and effectively.

Robust ICT clinical systems will continue to support the delivery of high quality, timely clinical services especially lab information system, pharmaceutical information system and radiology information system. ICT upgrades will include the expansion of Patient Management System (SPP) to more hospitals and the implementation of the Case Mix System in MOH hospitals.

Medical Records Services will be strengthened through infrastructure upgrades in selected hospitals and manpower strengthening. In an effort to solve the problem of storage for medical records centralization of medical records will be strengthened the record of hospitals and regional data warehouses established and this will reduce the data storage problems in state hospitals.

- Oral Health

Emphasis has to be directed into consolidation of efforts to address the high levels of tooth decay (caries) among preschoolers and toddlers. In addition to this, oral cancer has been identified as a new area of concern. Sustainance and expansion of the water fluoridation programme is crucial as fluoridation is recognized as the most cost effective public health measure for control of dental caries from cradle to grave.

- Telehealth

Consistent with Vision 2020, Malaysia aspires to harness the power of information and multimedia technologies to transform the delivery of health care and improve health outcomes. Towards this end, the focus will be on more transparent access to medical and administrative patient data, high quality patient health data management, active participation of patients in healthcare processes, improvement in the quality of current healthcare business processes and security and confidentiality of medical data.

- Pharmaceutical

Patient safety measures with regards to safe medication use are of priority. Adverse drug reaction (ADR) and Medication Error (ME) reporting systems which are already in place shall be strengthened through active promotion to various levels of healthcare providers; public and private to encourage reporting. Risk management strategies shall be developed to include multidisciplinary approach practice and training. Drug delivery to inpatients shall be improved through establishment of Unit Dose system to further improve medication safety.

vii. Knowledge Economy and Innovations

To ensure that the services sector meets our objective as one of the key drivers of economic growth, we have to constantly identify and venture into new higher value added services within sub-sectors that have been identified as having growth potential Knowledge-based services such as professional and technical services, ICT-based services and modern health care hold the greatest potential.

Malaysian healthcare providers must urgently strengthen their competitiveness in these service industries. Appropriate investments in supporting infrastructure, related R&D skills and human capital development are absolutely crucial in this regard and efforts towards this end by both the private and public sector will need to be intensified.

- Information Communication Technology (ICT)

To remain competitive, service providers will have to adopt the most modern and appropriate technology as well as maximize the use of ICT in their internal operations including their marketing and delivery. This is crucial to enhance the level of efficiency and productivity of service providers. This will call for greater appreciation for the use of ICT, change in mind set, greater readiness to make a change in the way they operate their businesses as well as new investments in ICT.

- Research & Innovation

The speed of changes in products and services is becoming more rapid with the advent of new technologies, and new processes replacing old processes. We need to respond to the challenge by re-engineering our organization and their value chain towards enhancing the delivery of healthcare. Hierarchies will need to become flatter thus reducing costs through the shortening of management chains and the focus on learning.

For the coming 10MP, research organizations will be required to identify new niche areas in order to support and subsequently play a more effective role. These will include:

- i) Monitoring and evaluation (M&E) especially in the domains relating to cost-effectiveness and performance measurement
- ii) Setting standards of care including the development of new clinical practice guidelines (CPGs) and in benchmarking with best practices internationally

- Human Capital

Sufficient financial allocation is required for the development of human capital, encompassing competency development as well as specialist and subspecialist training. Further enhancing the standardized national system for training and accrediting specialists would be a critically important way to address Malaysia's shortage of them. Exerting greater control over the entry of doctors into each specialty and their allocation among regions, both for training and full-time practice, would of course raise the level of state intervention but to achieve a good cause, if planned and implemented well.

7.4.2 Health Awareness & Healthy Lifestyle (KRA 2)

As part of the epidemiologic transition into the 21st century, chronic diseases specifically, cardiovascular diseases have become the leading cause of death and disability in most countries in the world. Hence, clinical and public health interventions aim to reduce the burden of chronic disease in populations. Epidemiologic data integrated within the context of unsustainable health care expenses defines a burning platform for prevention.

An environment supportive of good health is crucial in facilitating and achieving equity in health and lowering health costs. In the context of the expanding network of health services, health education has played a central role in creating health awareness and assisting people to stay healthy. Health education and promotion is an integral part of health services in this country and supports all health programs and activities at all levels from the community to national level. Therefore, for health promotion to operate in an effective way, it has to form viable partnerships even within the MOH itself and constantly strive to keep up with changing health needs and scenario of the time and be ready to

embrace new technologies and innovations in its search for excellence and improved delivery of services to the population.

Policies aimed at creating a healthier environment promote prevention. This approach must be expanded, together with the conceptualization and restructuring of the environment to promote physical activity. These and other public health measures should be envisioned as complementary to clinical care, because unhealthy societal choices that lead to illness result in unsustainable strain to the health care system. Measures proposed should result in the following:

- Reduction in mortality and morbidity, reduction of health inequality between groups and regions, better care of people with chronic conditions such as heart disease, hypertension and diabetes and avoidance of premature deaths, among others.
- Increased health literacy among the population and an increased proportion of the adult population practising health lifestyles

It is envisaged that concerted effort will result in a healthy nation and a community that values health. The main focus for 10MP will be in tackling the issue of obesity. Emphasis will be given to promote physical activity and healthy eating.

7.4.3 Empowerment of individual and community to be responsible for their health (KRA 3)

As an anticipated outcome in 10MP, the individual and community should be empowered through knowledge and skills to enable them to participate and subsequently make informed decisions to attain optimal health outcomes leading to a better Quality of Life. Strong healthy public policies and partnerships with NGOs, other agencies and the private sectors are crucial linkages in order to realize this outcome.

There are three result areas (RAs) for empowerment of self care which includes:

- i) The individual and community to have adequate knowledge and skill for self care.
- ii) Strong healthy public policies to support self care e.g. in nutrition, anti smoking, mental health etc.
- iii) Adequate supportive environment to act as enablers to empower individuals and communities. The environments that are important include those within the health facilities, schools and local authorities.

Whilst health promotion is the process of enabling people to increase control over, and to improve, their health, empowerment aims to enable people to take proactive action to promote the positive aspects of their lives. In other words, empowerment is the means to improve quality of life. This philosophy is based on the assumption that to be healthy, people need to have the psychosocial skills to bring about changes in their personal behaviour, their social situations, and the institutions that influence their lives. These skills probably play an important role in the development and implementation of; for example, a successful diabetes self-care plan that enhances the patient's health and quality of life.

8. DESIRED OUTCOMES AND STRATEGIES

MOH as lead agency in health has initiated consultative approach involving other agencies and sectors to deliberate on desired outcomes and the relevant strategies. This is done through Mission Cluster and Technical Working Groups (TWGs).

8.1. TECHNICAL WORKING GROUPS (TWG) – HEALTH SECTOR

The MOH has been entrusted by EPU to identify Technical Working Groups (TWGs) under the Thrust 4 Mission Cluster Group (MCG); Quality Healthcare & Active Healthy Lifestyle, involving inter-agencies and multisectoral membership. The Ministry has identified five TWGs as below:

1. Health Sector Transformation (Service Delivery)
2. Health Sector Transformation (Governance & Financing)
3. Health Sector Transformation (K-economy – Human capital, Information Technology, Research & Development / Innovation)
4. Health Awareness & Healthy Lifestyle
5. Empowerment of individuals and community to be responsible for their own health

Technical Working Groups (TWG) has been formed to identify strategies and outcomes that would ensure access to quality healthcare and promote healthy lifestyles. Each TWG has been assigned to deliberate on a specific topic and come out with recommendations – outcomes and strategies.

Based on TWG recommendations, MOH Programmes will, in turn, need to tease out TWG strategies and the recommendations, identify those that are relevant and come out with programme proposals for 10MP that will have an impact on MOH key result areas and contribute to the national effort to improve quality of life. This shall be in line with the five health sector functional programmes as the mode to allocate funding for the 10MP:

1. Population Health Programme
2. Personal Health Programme
3. Research & Innovation and
4. Human Capital Development Programme
5. Technical and Other Support Programme

Based on the groups' deliberation, several outcomes and strategies were consolidated and proposed as outcomes, strategies and KPIs for the MOH. Those outcomes and strategies are shown below:

Table 5: Outcome, Strategy and KPIs for Health Sector

HEALTH SECTOR KRA	OUTCOME	STRATEGI	HEALTH SECTOR OUTCOME KPI
I. Health Sector Transformation Towards A More Efficient & Effective Health System In Ensuring Universal Access To Healthcare	1. DELIVERY 1.1 Integrated public-private health services delivery	1. Streamline/realign healthcare delivery system <i>(keywords: PHC as thrust, gatekeeping, zoning, referral system, preventive/promotive, resource sharing, resource mobilization, appropriate technologies, registered population, registered providers)</i>	1. Integrated PHC and Secondary Care plan by 2015

HEALTH SECTOR KRA	OUTCOME	STRATEGI	HEALTH SECTOR OUTCOME KPI
1.2 Universal Access Equity of access-physical ease of access	1. DELIVERY 1.1 Integrated public-private health services delivery	2. Unified healthcare financing system (<i>keywords:</i> Safety net, financial risk protection, case mix, benefit packages, provider-payment mechanism, social health insurance, co-payment, increase government contribution, equity in resource allocation, equity in distribution of facilities, enforcement of PHFSA 1998, cost structure information)	1. All population will get access to the basic PHC services by (2014)
	1.3 High quality and safe care	3. Common quality and standard of care (<i>keywords:</i> Accreditation, credentialing, CPD, HTA, practice guidelines, clinical governance, care, uniform standard of care, standardised regulations, laws and enforcement) 4. Adequate and competent workforce (<i>keywords:</i> number, mix, competency, performance reward/incentive, quality, distribution)	1. Decrease mortality & morbidity of selected conditions
	2. FINANCE 2.1 Universal access Equity of access-financial	5. Strengthening healthcare legislation and enforcement (<i>keywords:</i> review, revise act & regulation, codes of ethic & conducts, capacity)	
	2.2 Cost containment		
	3. GOVERNANCE 3.1 Sustainability of healthcare delivery system	6. Strengthening implementation, monitoring and evaluation system (<i>keywords:</i> competency in stewardship, real time, data & information, research, evidence, informed decision, capacity)	
	3.2 Compliance to defined quality and standard	7. ICT as enabler (<i>keywords:</i> prerequisites for integrated unified system)	2. % of accredited facilities
	3.3 Responsiveness to population needs		3. Waiting time for selected procedures

HEALTH SECTOR KRA	OUTCOME	STRATEGI	HEALTH SECTOR OUTCOME KPI
II. Health Awareness & Healthy Lifestyle	<ol style="list-style-type: none"> 1. Malaysians will be health literate 2. Malaysian practise healthy lifestyle 	<ol style="list-style-type: none"> 1. Increase access to health knowledge <i>(keywords: innovative, incentive, empowerment, information sharing)</i> 2. Motivate individuals, family and community to acquire knowledge and skill <i>(keywords: innovative, incentive)</i> 3. Increase opportunities to practice healthy lifestyle at workplace, schools, home etc. 4. Formulate and enforce public policy towards healthy lifestyle 	<ol style="list-style-type: none"> 1. % health literacy (health literate to be defined later) 2. Increase in the percentage of physical activity of Malaysian adult 3. Reduce the prevalence of overweight and obesity among adult 4. Reduce the prevalence among adolescent smokers
III. Empowerment Of Individual And Community To Be Responsible For Their Health	Individuals, family and community to have adequate knowledge and skills to make decision about their health (selfcare, choice of treatment/provider)	<ol style="list-style-type: none"> 1. Strategies to increase health literacy 2. Provision of health information, including cost of care and governance policies 3. Providing avenues for effective complaints or enquiries regarding health providers 4. Mobilize civil society (NGOs, support groups, community leaders) 	% of individuals able to make decision on their own health

8.2. DESIRED OUTCOMES

At national level, the desired outcome is a healthy community protected by a health system that ensures universal access. At ministry level, the pragmatic outcomes include the establishment of a comprehensive health system that is efficient and effective through good governance and a community that practices healthy lifestyles and has access to quality and affordable care. These outcomes will be reflected by performance indicators of programmes and projects.

8.2.1. Health Sector Transformation towards A More Efficient & Effective Health System in Ensuring Universal Access To Healthcare (KRA 1)

Outcomes:

Delivery

- i. *Integrated public -private health services delivery*
- ii. *Universal Access - Equity of access – physical ease of access*
- iii. *High quality and safe care*

Finance

- i. *Universal access - Equity of access – financial*
- ii. *Cost containment*

Governance

- i. *Sustainability of healthcare delivery system*
- ii. *Compliance to defined quality and standard*
- iii. *Responsiveness to population needs*

8.3. STRATEGIES TO ACHIEVE OUTCOMES

The consolidated strategies are interrelated. An outcome may have one or several related strategies, a strategy may also contribute to one or more outcomes.

This section elaborates the details of MOH strategies to achieve the three identified MOH KRAs which are the establishment of a comprehensive healthcare system i.e. a transformed health sector delivery system that is efficient and effective to ensure universal access (see KRA 1) and having a healthy communities that has access to quality healthcare, empowering individual and community to be responsible for their health through health awareness and healthy lifestyles (see KRA 2 & 3).

8.3.1 Health Sector Transformation Towards A More Efficient & Effective Health System In Ensuring Universal Access To Healthcare (KRA 1)

a. Streamline/ realign healthcare delivery system⁹

The important issue relating to health delivery is the present structural dichotomy in the delivery of care, the resulting inequity, the differences in quality, the need to standardize care and a private sector that concentrates on curative care. Adaptable delivery roles and structures allow flexible care settings and expanded clinical roles providing avenues for care that are centered on the needs of the patient.

The restructured national health system is one that is responsive and provides choice of quality health care, ensuring universal coverage for health care needs of population based on solidarity and equity. The restructuring proposal aims at integrating care, initially at primary care level, and providing a sustainable healthcare financing that is fair and providing financial protection to those who cannot afford it.

The proposed restructured Malaysian Health System will retain the existing strengths of the current system. Personal health care services will be devolved. The role of the MOH will be more streamlined involving the following:

- Governance and stewardship
- Selected public health services

The objective is an integrated system that ensures universal coverage through equity of access, with efficiency linked to PHC playing the pivotal role as gatekeeper together with other cost containment measures. This will be facilitated by a system

⁹keywords: Primary Health Care (PHC) as thrust, gate keeping, zoning, referral system, preventive/ promotive, resource sharing, resource mobilization, appropriate technologies, registered population, registered providers

of financing that is fair and protects from catastrophic expenditure. The financing will be a mix of government funding and social health insurance with an option to buy extra coverage through private health insurance or out-of-pocket. The fund will be managed publicly. The government should ensure that programmes that deliver public goods are adequately funded.

Preventive care and disease management programs have untapped potential to enhance health status and reduce costs, but require support and integration across the health sector for their benefits to be realized. The most effective means of demand management are wellness, immunization and disease management programs. Lack of care integration and continuity is a major problem facing the health delivery system.

Improvement in the delivery of care is envisaged through an integrated delivery system that enables services to be obtained from both public and private sector. This would result in better use of resources, access, and response from service providers and ensure that quality of care is uniform. Enforcement of the PHFSA 1998 and tax incentives should ensure a more equitable distribution of facilities, in particular private enterprises to less developed areas. The exercise to update inventory of health and health related facilities and resources will facilitate decision making

Significant departures from current practice would be needed to implement alternatives such as pay-for-performance programs to rewarding the human capital for high-quality care and penalizing them for inadequate or inefficient care, or the use of generic drugs through forced substitution (requires pharmacies to fill prescriptions with generic equivalents whenever possible) or generic reference pricing (requires patients who wish to receive an originator drug to pay the full cost difference between that drug and its generic equivalent, as well as the copayment for the generic drug) which would free up funds for new, innovative, and often more expensive treatments. These measures will call for a significant communications effort to explain and show what and why these are needed.

b. Unified healthcare financing system¹⁰

Future health spending is expected to increase at a much higher level of growth than in the past. By 2020, healthcare spending is projected to triple in real dollars, now consuming 4.7 % of GDP (2007). Governments, hospitals and doctors are seen as having the greatest opportunity to eliminate wasteful spending in healthcare. There is wide support for a health system with shared financial risks and responsibility among private and public payers and providers rather than a cost-shifting approach. Financial responsibility should be shared and competition, taxpayer funding of some or all of healthcare, regulated cost controls, and cost sharing by patients are important.

The financial issues discussed include allocative efficiency, efficiency in the use of resources, cost effectiveness and availability of financial data and information in particular from the private sector¹¹, among others. Annual reports should be made available from providers and facilities in both sectors. ICT networks need to be established to link all facilities for information to be open and transparent. Related issues addressed include the following:

- Provider-payment mechanism that will reduce moral hazards and wastage. This include packaging for services rendered, replacing fee-for-service in the private sector with DRG or equivalent, a system of capitation and co-payment or user fees to manage supply and demand respectively and incentives via pay-for-performance (P4P) or result-based financing (RBF). The other recommendations include a single paying authority and a fee schedules that is updated regularly. In the long run this, together with enforcement of regulations, will lead to cost containment.

¹⁰keywords: Safety net, financial risk protection, case mix, benefit packages, provider-payment mechanism, social health insurance, co-payment, increase government contribution, equity in resource allocation, equity in distribution of facilities, enforcement of PHFSA 1998, cost structure information

¹¹to allow for comparison of cost and analysis of cost variation

- System of accounting in the public sector that does not allow for detailed unit costing. While waiting for a shift to accrual accounting, it would be wise to revive, revise and upgrade micro-accounting (or ABC) that was initiated in the eighties.

In support of more empowered consumers, pay-for-performance and increased cost sharing is important but are hospital systems prepared to meet the demands of empowered consumers. In this context, direct cost sharing by patients is an effective or very effective method to manage demand for healthcare services.

c. Common quality and standard of care¹²

A clearly defined and enforced quality, safety and clinical standards establish mechanisms for accountability and enhanced transparency, thereby building consumer trust. Good governance in ensuring quality and safety is paramount in a service which deals with life and limb. This needs to be complemented with policy to mandate all facilities and services to obtain accreditation and ISO certification. Realignment of incentive systems can ensure and manage access to care while supporting accountability and responsibility for healthcare decisions. Strengthen medical audit and health technology assessment as part of clinical governance.

d. Adequate and competent workforce¹³

Good governance mandates that there is monitoring of the market and intervention when signs of market failure such as over servicing and abuse of service surfaces as well as advocacy for more funds when necessary. Other concerns such as competency of professional, use of unlicensed and untrained staff, transparency in clinical governance and questionable advertisement have evoked the recommendation to ensure professional competency, practice standards, appropriateness of care and patient safety. This encompasses a system of credentialing, revalidation and re-certification and the setting up of a national institute of clinical excellence.

e. Strengthening healthcare legislation and enforcement¹⁴

Review of legislation and effective enforcement of existing laws. The establishment of one healthcare enforcing agency is recommended for more effective enforcement.

f. Strengthening implementation, monitoring and evaluation system¹⁵

The provision and accessibility to health service is related to and supported by knowledge based activities such as Human Capital Development, Information Technology, Research & Development / Innovation. Availability and capability of staff requires a review of norms, training needs and capacity to train. A complementary strategy is the optimum deployment of health service provider based on needs, together with a reduction in the misdistributions of manpower. Establishing a climate of innovation means innovation, technology and process changes are a means to continuously improve treatment, efficiency and outcomes.

Manpower management needs to look at new models of developing, recruiting and retaining manpower to address the root causes of gaps in service and impending future needs. Efforts are to consolidate and increase the supply of human capital. These include optimization of the use and allocation of resources to ensure the well-being and quality of life in Malaysia through equitable access to community health services, increase accessibility to healthcare services through adequate supply of quality workforce and competency development programme focusing on improving the quality of healthcare services through the development of a competent workforce.

¹² *keywords:* Accreditation, credentialing, CPD, HTA, practice guidelines, clinical governance, care, uniform standard of care, standardised regulations, laws and enforcement

¹³ *keywords:* number, mix, competency, performance reward/ incentive, quality, distribution

¹⁴ *keywords:* review, revise act & regulation, codes of ethic & conducts, capacity

¹⁵ *keywords:* competency in stewardship, real time, data & information, research, evidence, informed decision, capacity

g. ICT as enabler ¹⁶

Information technology (IT) is an important enabler in resolving healthcare issues when there is system wide and organizational commitment and investment. IT is very important to integrate care and improve information sharing but IT is not a solution in and of itself. IT is also important for improving patient safety and restoring patient trust. An important strategy is the interoperable and integrated health IT system throughout the health sector, creation of a body to promote adoption of health informatics standard in the country and development of National Policy on accessibility, confidentiality, and integrity of personal health information.

There are success stories that have already surfaced: several hospitals, states have markedly reduced waiting time, ER utilization, for example, through relatively simple measures, such as a telephone consultation service, use of IT and a public education campaign. The transformation can be in stages and not be an all or nothing change or taking place all at once. Shifting expectations away from stop gap and quick fixes such as for across-the-board fees for doctors or lower prices for pharmaceuticals will be an important part of the process.

8.3.2 Health Awareness & Healthy Lifestyle (KRA 2)

The MOH will formulate public policies to support healthy lifestyles, strengthen health promotion and ensure that dubious claims and advertisements are prevented from reaching the public. This means better access to and vetting of health information in areas such as nutrition, anti-smoking, mental health to name a few.

The MOH will work closely with related agencies to increase opportunity to support active healthy lifestyle through provision of public recreational and sports facilities. The development of a National Council on Healthy Lifestyle to coordinate multi-agency efforts and a healthy lifestyle surveillance system is high on the agenda.

It is hoped that through concerted effort the percentage of physical inactivity among Malaysian adults will reduce by 10% (NHMS 2006 - 43.7%), the prevalence of overweight and obesity among adult reduced by 0.4% and prevalence among adolescent smokers reduced by 3% (NHMS III, 8.7%). As there is a dearth of social information, studies will be undertaken to obtain baseline data on health literacy and healthy lifestyle practices. The strategies are:

- a. Increase access to health knowledge¹⁷
- b. Motivate individuals, family and community to acquire knowledge and skill¹⁸
- c. Increase opportunities to practice healthy lifestyle at workplace, schools, home etc.
- d. Formulate and enforce public policy towards healthy lifestyle

8.3.3 Empowerment Of Individual And Community To Be Responsible For Their Health (KRA 3)

Empowerment of individuals and community to be responsible for their own health involves the enhancement of health literacy through educating individuals and communities with adequate knowledge and skills for self care. This should be complemented by a supportive environment to act as enablers to empower individuals and communities such as establishing and strengthening community actions and initiatives, building partnerships and intersectoral collaboration and nurture health champions. The relevant strategies are:

¹⁶ *keywords:* prerequisites for integrated unified system; digital backbone towards better use of technology and interoperable electronic networks accelerate integration, standardization, and knowledge transfer of administrative and clinical information

¹⁷ *keywords:* innovative, incentive, empowerment, information sharing

¹⁸ *keywords:* innovative, incentive

- a. Strategies to increase health literacy
- b. Provision of health information, including cost of care and governance policies
- c. Providing avenues for effective complaints or enquiries regarding health providers
- d. Mobilize civil society (NGOs, support groups, community leaders)

9. INTEGRATED MONITORING AND EVALUATION

9.1 TRANSPARENCY AND GOVERNANCE

Transparency is required in new payment and reporting methods that are emphasizing safety, performance and accountability for health organizations across the health sector. Payers and providers are supporting pay-for-performance programs and industry groups are establishing quality and safety standards. Governments are establishing reporting mechanisms and requirements. According to United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), the eight criteria of Good Governance are participation, consensus orientation, accountability, transparency, responsiveness, effectiveness, equity and abidance by the rule of law.

Governance influences all other health system functions, thereby leading to improved performance of the health system and ultimately to better health outcomes. Finally, a requirement of governance is the existence of adequate capacity and effective systems that contribute towards health sector development such as human capital; studies, research and rapid innovations; as well as IT-enabled mechanisms for obtaining timely information on the existence of appropriate, timely and effective access, utilization and funding of health services.

9.2 INTEGRATED AND COMPREHENSIVE INFORMATION SYSTEM

A requirement of governance is the existence of effective systems such as research and rapid innovations as well as mechanisms for obtaining timely information on the existence of appropriate, timely and effective access and utilization of health service that contribute towards health sector development. Furthermore, there is now a growing need for an integrated health information system and comparable information to ensure continuity of care and reduced duplication to be used in healthcare as people make transitions from one sector of the health system to another. Health information and communication technologies have enormous potential to play a significant role to transform healthcare with respect to the quality of care in terms of timeliness, better decision making, decreasing errors and patient safety.

9.3 OUTCOMES AND KEY PERFORMANCE INDICATORS (KPIs)

The most pertinent thing in ensuring success of a program is to monitor the intended outcome and evaluate the data that comes with be it in the form of quantitative (measurable outcome) or qualitative. Health outcomes are the result of many activities, health and health related ones. Thus there is a need for an integrated monitoring and evaluation system. There is a need to share, collect and collate data from ministries responsible for recreational infrastructure and other lifestyle related activities, among others, and relate to efforts of MOH. A pre-requisite is a good information system that will collect comprehensive data from both the public and private system, analyse and distribute findings and reports.

This will assist the MOH in the following:

- to analyse and appraise progress of development programmes and projects of the related sector in the 10MP
- to identify issues and problems that hinders effective implementation

- to propose remedies and/or alternative actions to ensure outcome objective is achieved

Health sector KRAs, strategies, outcomes and KPIs as tabulated in table 6 will need to be incorporated into a common monitoring and evaluation system bearing in mind that financing and governance cuts across all service provision and support programmes. Monitoring process will be carried out at various stages, such as:

- Planning stage
- Preparation stage
- Implementation stage

However, to measure or evaluate objectively is a challenging task due to the fact that many of the programmes are long term processes and sometimes results are hard to specify and quantify. The challenge is to measure/evaluate/capture processes and relational changes that are less predictable, less tangible, more contextual and more difficult to quantify in data collection and analysis. For example, empowerment, being a subjective matter will require a more extensive method to evaluate. Evaluation will have to include both process and outcome of empowerment for individual and also the community. Apart from operational data and information, studies to evaluate the attainment of the outcome and KRAs will need to be done e.g. National Health Morbidity Survey (NHMS), Burden of Disease, Household and health surveys, nutritional and lifestyle studies. It is suggested that the studies be done early in 10MP and another study at the end of 10MP. These studies will enable the MOH to gauge the level of progress and achievement and identify barriers to the effective implementation.

10. SUMMARY & CONCLUSION

10.1 SUMMARY

Malaysia has to confront the familiar and unpleasant task to make the right choices to provide its citizens with affordable, high-quality health care. By making the right choices, it can control health system costs without compromising access or quality. Malaysia has to undergo health transformation as she builds a health system for the future. The future healthcare requires reshaping from a system that is largely disease-based medical care focused on illness, facilities and healthcare providers to personalized healthcare that is focused on wellness, people and the capacity to deliver services into people's homes. There are numerous challenges, such as:

- Addressing rising healthcare cost and increasing resources towards a sustainable health system
- Meeting increasing needs, wants (and demands) due to increasing affluence (rapid economic growth) fuelling demand and rising public expectations
- Responding to changing demography, ageing and migration, disease burdens and transition
- Managing expensive, overutilization and underutilization of new technologies and medical advances
- Responding to variations in distribution of delivery (universal access, responsiveness) and quality and standards of care in health services
- Redistributing resources concentrated in the very expensive hospital sector instead of primary care level where services can be more cost effective and conveniently delivered
- Increasing capacity and redistributing of health workforce/health professionals
- Addressing tendency to deliver episodic and fragmented care as continuity of care is a major concern
- Enhancing integration of healthcare delivery using integrated health records and Telehealth/IT efforts
- Managing the public-private dichotomy
- Responding to increasing public scrutiny and demands for performance and accountability with regards to the above challenges

Health care industry leaders must face up to the challenges. They must focus and align:

1. New effective management approaches to governance and organizations of the health services delivery and financing system including quality management and emphasis on human capital development (HCD)
2. Industries related to knowledge and services in health especially in information technology and, increasing medical research in biotechnology
3. Health information in health services and consultancy in health management that contributes towards economic growth by enriching knowledge in those areas
4. Basic scientific knowledge and research will become the driving force to create, utilize and generate new knowledge databases and technology, provide innovation opportunities and possibly creating new industries. Some other issues include the importance of basic health research funding, R&D incentives
5. Rapid pace of innovation in health and health related fields including
 - a. complementary/ alternative/ traditional medicine and health
 - b. the policy and regulatory process
 - c. improved diffusion and access to new health knowledge, services and product
 - d. IT infrastructure and basic health intranet requirements to enhance connectivity and interoperability.

Specific areas to look into include:

- Costs and future health spending is expected to increase at a much higher level of growth than in the past. By 2020, healthcare spending is projected to more than double in real ringgit, now consuming 4.7 % of GDP (2007). Governments, hospitals and doctors are seen as having the greatest opportunity to eliminate wasteful spending in healthcare. There is wide support for a health system with shared financial risks and responsibility among private and public payers and provides rather than a cost-shifting approach. Financial responsibility should be shared and competition, taxpayer funding of some or all of healthcare, regulated cost controls, and cost sharing by patients are important.
- Capacity building especially for human capital and funding as well as strategic deployment and allocation will appropriately satisfy competing demands and to control costs while providing sufficient access to care for most people. A clearly defined quality and safety standard and a better enforced clinical standards will result in better mechanisms for accountability and enhanced transparency, thereby building consumer trust
- Health promotion, preventive care and disease management programs have untapped potential to enhance health status and reduce costs, but require support and integration across the health sector for their benefits to be realized. The most effective means of demand management are wellness, immunization and disease management programs. Lack of integration and continuity is a major problem facing the health delivery system.
- Incentives and realignment of incentives can ensure and manage access to care while supporting accountability and responsibility for healthcare decisions. In support of more empowered consumers, pay-for-performance and increased cost sharing approaches are important but are various health subsystems especially hospitals prepared to meet the demands of empowered consumers. In this context, direct cost sharing by patients is an effective method to manage demand for healthcare services.
- Technology and information technology (IT) is an important enabler in resolving health issues when there is system wide and organizational commitment and investment. It is very important to be transparent towards integrating services and improving information sharing but IT is only part of the solution towards improving patient safety and restoring patient trust. Technology assessment relative to productivity and lifespan and its dissemination require establishing infrastructure and communications standards and developing incentives that will distribute the risks and rewards more evenly.

- Research and innovation, technology and process changes are a means to continuously improve treatment, efficiency and outcomes. In this pursuit, collaborations, adaptable delivery roles and structures will allow innovative and flexible care settings and expanded clinical roles provide avenues for care that are centered on the needs of the patient.

10.2 CONCLUSION

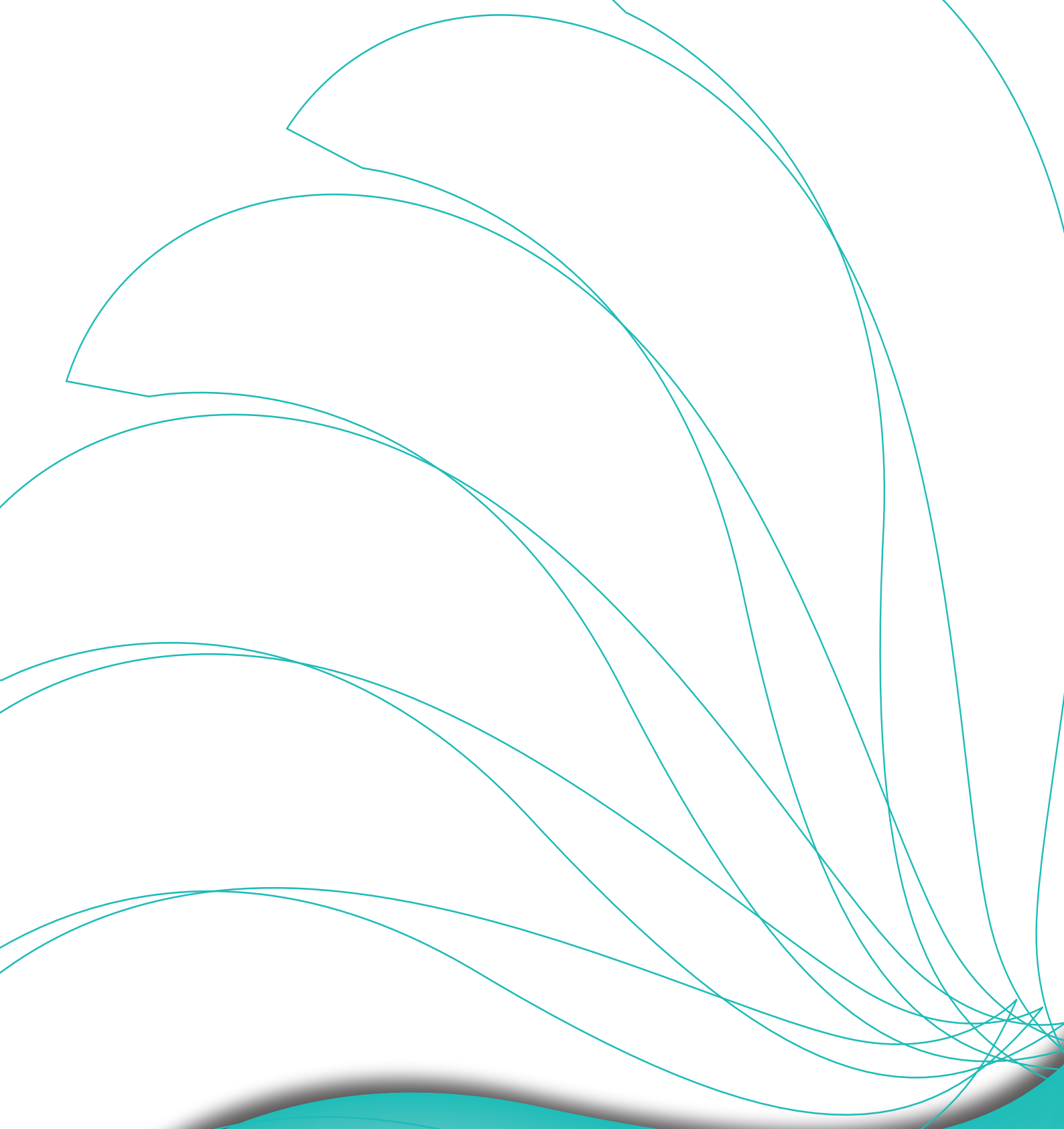
There is growing awareness that effective investment in health is vital to human development and poverty reduction. The 10MP emphasis on health is timely and will go a long way to attain an enhanced quality of life befitting a developed nation. Malaysia needs to avoid from relying on pure market solutions to overcome some of its health challenges. Health is different since individuals do not know when they will fall ill and the costs involved if they do. Also, effectiveness and efficiency are influenced by a complexity of distributional issues and asymmetry of information. Malaysia should thrive to work harder to push for the best possible outcome in health contributing to the desired quality of life vis-à-vis towards realising Vision 2020.

Arguably, the performance of MOH will need to be judged on achieving its outcomes, goals and objectives. It also depends on how the Malaysian community views the importance of equity in health/ health care and hence the amount of extra resources (as well as cost-control or efficiency) individuals, family and community would be prepared to sacrifice in order to obtain more equity (and quality). Success will require a transformation agenda addressing pertinent building blocks that include health financing, human capital development, improving and enforcing the quality and standards of care, value based healthcare, governance, emergency and crisis preparedness, and making research and IT as enablers for health sector development. The focus on the building blocks will not only assist the transformation but help ensure the sustainability of universal access and quality care during the 10th and subsequent Malaysia Plans.

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APPENDICES

APPENDIX 1

PROGRAMME AND ACTIVITIES OF MOH IN 10MP

The list of Programmes and proposed Activities* of MOH during the Tenth Malaysia Health Plan are as follows:

MANAGEMENT

1. Human Resource Division
2. Training Management Division
3. Competency Development Division
4. Information Management Division
5. Management Division

FINANCE

1. Finance Division
2. Procurement Division
3. Account Division

PUBLIC HEALTH

1. Family Health Development Division
2. Disease Control Division
3. Food Safety & Quality Division
4. Health Education Division
5. Nutrition Division

DENTAL HEALTH

1. Dental Policy & Development Division
2. Dental Practices, Control and Promotion Division

MEDICAL

1. Medical Development Division
2. Medical Practices Division
3. Telehealth Division
4. Allied Health Division
5. Nursing Division

RESEARCH

1. Planning & Development Division
2. Engineering Services Division
3. Medical Device Bureau Division
4. Traditional & Complementary Medicine Division
5. Secretariat of National Institute for Health

PHARMACY

1. Pharmacy Enforcement Division
2. Pharmacy Practice & Development Division
3. Pharmacy Regulatory Division

OTHERS

1. Legal Advisor Division
2. Internal Audit Division
3. Policy & International Relation Division
4. Corporate Communication Unit

APPENDIX 2

GUIDELINES AND CIRCULARS RELEVANT TO THE PREPARATION OF 10MP

1. Garis Panduan Pertama Penyediaan RMKe-10, 2011-2015 Prospek Ekonomi dan Halatuju Strategik (www.epu.gov.my)
2. Garis Panduan Kedua RMKe-10 : Penyediaan Pelan Pelaburan Sektor Awam, 2011 – 2012 (www.epu.gov.my)
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4. Pekeliling UPE, JPM Bil 2. Tahun 2009 : Garis Panduan dan Peraturan Pemilihan Tapak, Perancangan Bangunan dan Keperluan Peralatan (www.epu.gov.my)
5. Pekeliling UPE, JPM Bil 3 tahun 2009 : Garis Panduan Pengurusan Nilai (www.epu.gov.my)
6. Surat Pekeliling Perbendaharaan Bil 7 Tahun 2008 : Pelaksanaan Industrialised Building System (IBS) dalam Projek Kerajaan (www.treasury.gov.my)
7. Pekeliling Unit Kerjasama Awam Swasta Bil 1 Tahun 2009 : Garis Panduan Kerjasama Awam Swasta (Public Private Partnership – PPP) (www.3pu.gov.my)

APPENDIX 3

GUIDING PRINCIPLES FOR 10MP

VISION 2020

Vision 2020 has set the goal for the country to become a fully developed nation in the Malaysian mould with its own characteristics and positive values. It states that *“by the year 2020, Malaysia is to be a united nation with a confident Malaysian Society infused by strong moral and ethical values, living in a society that is democratic, liberal and tolerant, caring, economically just and equitable, progressive and prosperous, and in full possession of an economy that is competitive, dynamic, robust and resilient”*.

Vision 2020 has nine strategic challenges:

- a) The challenge of establishing a united Malaysian nation with a sense of common shared density.
- b) The challenge of creating a psychologically liberated, secure and developed Malaysian.
- c) The challenge of fostering and developing a mature democratic society.
- d) The challenge of establishing a fully moral and ethical society.
- e) The challenge of establishing a mature, liberal and tolerant society.
- f) The challenge of establishing a scientific and progressive society.
- g) The challenge of establishing a fully caring society and a caring culture.
- h) The challenge of ensuring an economically just society and
- i) The challenge of establishing a prosperous society.

NATIONAL MISSIONS THRUST

Thrust 1 : To move the economy up the value chain

Thrust 2 : To raise the capacity for knowledge and innovation and nurture ‘first class mentality’

Thrust 3 : To address persistent socio-economic inequalities constructively and productively

Thrust 4 : To improve the standard and sustainability of quality of life

Thrust 5 : To strengthen the institutional and implementation capacity

NATIONAL VISION POLICY (OPP3)

This is the long-term plan in the country established in 1970 and currently it is at the Third Outline Perspective Plan (OPP 3) for the period 2000-2010. The National Development Policy of the OPP 3 is based on the principle of growth with equity and is aimed at alleviating poverty and eliminating economic imbalances among communities and regions. It is based on the context of balanced development and social justice so as to achieve the overriding goal of national unity.

The seven elements of the National Vision Policy are:

- Building a resilient nation
- Promoting an equitable society
- Sustaining economic growth
- Meeting global competition
- Developing a knowledge-based economy
- Strengthening human resources development
- Pursuing environmentally sustainable development

NATIONAL INTEGRITY PLAN

The “Pelan Integriti Malaysia (PIN)” or the National Integrity Plan (NIP) was formulated to fulfil the fourth strategic challenge of Vision 2020, that is, *“to mould a strong community with moral and ethical features with citizens who possess spiritual and religious strengths and uphold good deeds”*.

The main targets of the NIP called “Determinants 2008” are:

1. Effective decrease of bribery, extravaganzas and misuse of power
2. Improve effective public services and reduce bureaucratic procedures
3. Improve corporate administration and ethical businesses
4. To strength the institution of the family
5. To improve the quality of life and community safety

NATIONAL ECONOMIC RECOVERY PLAN

The national economic crisis in the year 1997 was a result of the depreciation of the Ringgit and the collapse of the stock market. The Malaysian government introduced the National Economic Recover Plan (NERP) to address the crisis and its pervasive negative effects on the Malaysian economy and its people.

The six key areas for action in this plan are:

1. Stabilizing the ringgit
2. Restoring market confidence
3. Maintaining financial market stability
4. Strengthening economic fundamentals
5. Continuing the equity and socio-economic agenda
6. Restoring adversely affected sectors

6 National Key Result Areas:

KRA1 : Reduction of Crime Rate

KPI1.1 : Reduce Street Crime by 20% by 2010

KRA2 : Combat Corruption

KRA3 : Widening Access to Affordable and Quality Education

KRA4 : Raising the Living Standard of the Poor

KRA5 : Improving the Infrastructure in Rural Areas

KPI5.1 : Add 1,500 km roads in Sabah and Sarawak by 2012

KPI5.2 : Not more than 5km of walking to tar roads in Peninsular by 2012

KPI5.3 : Clean water supply to 90% of Sabah and Sarawak by 2012

KPI5.4 : Electricity cover of 95% in Sabah and Sarawak by 2012

KPI5.5 : 24-hour electricity supply to 7,000 orang asli families in Peninsular by 2012

KRA6 : Improving Public Transport in the Medium Term

KPI6.1 : Increase the number of public transport users from 16% to 25% by 2012

KPI6.2 : Add 35 sets of four-car trains on Kelana Jaya LRT by 2012

These KRAs are important for providing the basic rudiments of a modern life to all Malaysians.

VISION

A nation working together for better health.

MISSION

The mission of Ministry of Health is to lead and work in partnership:

- i. to facilitate and support the people to:
 - attain fully their potential in health
 - appreciate health as a valuable asset
 - take individual responsibility and positive action for their health

- ii. to ensure a high quality health system that is:
 - customer centred
 - equitable
 - affordable
 - efficient
 - technologically appropriate
 - environmentally adaptable
 - innovative

- iii. with emphasis on:
 - professionalism, caring and teamwork value
 - respect for human dignity
 - community participation

GOALS OF HEALTH SERVICES

The ultimate aim of the health sector is to optimally raise and sustain the health status of individuals, families and communities through health promotion, preventive, curative and rehabilitative services so as to enable them to lead a socially and economically productive life, and to enjoy an acceptable quality of life.

The 8 Health Services Goals are:

- Wellness focus
- Person focus
- Informed person
- Self help
- Care provided at home or close to home
- Seamless, continuous care
- Services tailored to individual or group needs
- Effective, efficient and affordable services

APPENDIX 4

FORMAT FOR PROGRAMME AND ACTIVITY HEALTH PLAN

The format for Book II is suggested as follows:

(Note: This is just a guide)

1. Executive Summary

2. Introduction

3. Summary of 9MP Progress and Prospects

Programmes and Activities are required to **summarize** their achievements and shortfalls and state the future prospects. (The Programme and Activities may use their report on the Programme/Activity Situational Health Analysis which was sent earlier to Planning & Development Division).

4. Summary of Issues and Challenges

Programmes and Activities are required to **summarize** their issues and challenges relating to their respective areas. The challenges should include overcoming shortfalls and moving forward in line with national and health sector priorities (The Programme and Activities may be extracted from the State / Country Situational Health Analysis, Programme / Activity Situational Health Analysis and Evaluation of the 8MP and 9MP and the document 'Tenth Malaysia Country Health Plan: (Book I).)

5. Key Result Areas

All Programmes and Activities must subscribe to the identified national and health sector key result areas (KRA), outcomes and strategies outlined in Book I.

6. Strategies / Future Directions

Identify the Programme strategies that are to be used to achieve the stipulated key result areas (KRA) and outcomes. The Programme strategies must be in line with the broad health sector strategies in Table 7 and Table 8 (pg 74 & 79).

7. Proposed Programmes and Projects

Programmes and Projects proposed must be in-line with the National Health Sectors Development Programme. The MOH has identified 5 broad functional Programmes (as mentioned in page 62 para 5).

The Programmes are required to identify the programmes and projects according to the national and health sector KRAs and outcomes. The non physical project priorities identified are human resource development, ICT, financing, risk communication for social health insurance, equipments for existing facilities and research. This also includes programmes such as reduction in obesity and smoking programmes

8. Monitoring and Evaluation: Indicators and Targets

Identify the Programme indicators and targets to be used for monitoring and evaluating the objectives and strategies during the 10MP period. The identified Health Sector Outcome KPI must be monitored by the respective Programme and/or Activities in addition to their own KPIs. Availability of data for indicator must be given special emphasis. Data must be available for collection at appropriate times (if possible, use end of 9MP as baseline data)

9. Conclusion

10. References and Appendices

APPENDIX 5

THE TENTH MALAYSIA HEALTH PLAN CONFERENCE RESOLUTION

The government has set a transformation agenda in the 10th Malaysia Plan (10MP) to achieve VISION 2020 where Malaysia shall become a high income nation, through the 5 National Mission Thrusts. Mission Thrust 4 relates directly to health that is to improve the standard and sustainability of quality of life. This underlies the importance of a healthy population which is essential for a competitive, efficient and productive nation. The ability to make the right lifestyle choices is the hallmark of a healthy population.

To achieve the above, there is a need for a comprehensive healthcare system that is equitable, affordable, effective and efficient in terms of delivery and financing, complemented by an environment that empowers individuals and community to practice healthy lifestyle and be responsible for their own health.

The Conference:

Taking note of the issues in the current healthcare system which includes:

- Escalating healthcare costs
- Growing public-private dichotomy
- Changing trends in diseases and socio-demographic patterns
- Rising expectations of the public
- Leakages of and dependence on government subsidized services
- Imbalance in the distribution of resources and workload
- Existing gap between healthy lifestyle knowledge and practices

Agreeing fully with the 10MP Health Plan theme '1Care for 1Malaysia'. (1Care is a restructured national health system that is responsive, provides choice of quality health care and ensures universal coverage for health care needs of population based on solidarity and equity).

Endorsing the three Key Result Areas (KRA) of the Health Sector for the 10MP which are :

- Health Sector Transformation (health services delivery, governance & financing)
- Health Awareness & Healthy Lifestyle
- Empowerment of Individuals and Community to be responsible for their own health

Appreciating our past and present achievements and acknowledging the current and future constraints faced by the health sector

Deliberating on previous proposals of the Technical Working Groups (TWGs)

Taking cognisance of the direction given in the opening speech, keynote address and presentations by heads of programmes

Resolves to:

1. Transform the health sector to be more equitable, effective and efficient.
2. Strengthen the governance and stewardship role of the Ministry of Health
3. Integrate the public-private health services.
4. Place emphasis on wellness, promote healthy lifestyle and
5. Empower individuals and community to be responsible for their own health.

The Conference hereby:

1. Adopts the concept of '1Care for 1Malaysia'.
2. Urges all stakeholders to respond to Health Sector KRAs' outcomes, strategies and activities which have been identified for the 10MP health plan.
3. Further urges all stakeholders to prioritise and implement programmes and activities with respect to the following three KRAs :

3.1 Health Sector Transformation Towards a More Efficient & Effective Health System in Ensuring Universal Access to Healthcare

- i. Transforming the healthcare delivery system in phases beginning with the integration of public -private health services at Primary Care level and driven by a unified healthcare financing system
- ii. Making the Primary Care services, which provide effective and efficient care coordination and gate keeping, the thrust of the healthcare system.
- iii. Transforming the healthcare delivery system to provide accessible high quality care to all.
- iv. Strengthening of primary, secondary and tertiary care services by enhancement of networking, referral system and zoning of the public and private facilities.
- v. Establishment of seamless care and ensuring universal access and equity by upgrading facilities, and improving capacity, skills and competency of healthcare providers, facilitated by ICT.
- vi. The quality of care in both sectors shall be enhanced through accreditation, credentialing and privileging processes.
- vii. Redeployment of personnel to underserved areas
- viii. Practice cost containment and prudent financing for efficient delivery of services. Activities include auditing, case-mix costing, determining pricing policy and co-payment
- ix. The Government shall continue to play its stewardship role and finance public health programs, ensure quality of care and enforce all health laws and regulations.
- x. There is a need for a comprehensive legislation to support 1Care. This includes review and amendments of existing health laws and promulgation of new ones.

3.2 Health Awareness & Healthy Lifestyle

- i. To increase access to health knowledge through conducting Healthy Lifestyle Campaigns, using social marketing strategy, initially targeted at school children with a focus on healthy eating, physical activity, anti-smoking and mental health.
- ii. To motivate individuals, family and community to acquire knowledge and skill through the establishment of interactive Healthy Lifestyle initiatives at strategic locations.
- iii. To increase opportunities to participate and practice healthy lifestyle in various settings using structured intervention programmes within a supportive environment.
- iv. To formulate, regulate and enforce public policies in healthy lifestyle incorporating elements of incentives and disincentives.
- v. To strengthen the implementation, monitoring and evaluation of healthy lifestyle programmes and activities through advocacy, intersectoral collaboration and establishment of Behaviour Surveillance System.

3.3 Empowering Individuals, Families and Community to Be Responsible For Their Health

- i. To increase health literacy by providing health information and facilitate adoption of good health practices through creative and innovative interventions
- ii. To build capacity among individuals, families and community to enable them make healthier choices through the creation of supportive environment.
- iii. To mobilize civil societies to participate in high impact community- based health activities towards enhancing social change
- iv. To emphasize and enhance the role of the primary healthcare providers in empowering individuals, families and community

4. Requests that all stakeholders to further improve on the good progress made and continuously

5. Urges the Ministry of Health, as the lead agency, to hasten the implementation of the transformation framework.

6. Further urges the central agencies and other stakeholders to support this resolution.

The conference believes that this transformation will bring the healthcare system to a level that is commensurate with a developed nation status.

APPENDIX 6

PROGRAMME OF THE TENTH MALAYSIA HEALTH PLAN CONFERENCE

Objektif Persidangan:

1. Membentangkan Pelan Strategik Kesihatan RMK-10 sejajar dengan hala tuju kerajaan ke arah negara berpendapatan tinggi.
2. Mendapatkan input serta cadangan program dan aktiviti selaras dengan Pelan Strategik Kesihatan RMKe-10 berdasarkan konsep 1Care for 1Malaysia.

2 FEBRUARI 2010 (SELASA)

0700 - 0800	:	Pendaftaran Peserta
0800 - 0825	:	Peserta mengambil tempat
0825 - 0830	:	Bacaan Doa
0830 - 0920	:	Ucaptama Persidangan Oleh : Ketua Pengarah Kesihatan Malaysia Y. Bhg. Tan Sri Dato' Seri Dr. Hj. Mohd Ismail Merican
0920 - 0940	:	Minum Pagi
0940 - 1020	:	Pembentangan Cadangan Pelan Strategik Kesihatan RMKe-10 Oleh : Pengarah Perancangan dan Pembangunan Kementerian Kesihatan Malaysia Dr. Hj. Abd. Rahim B. Hj. Mohamad
1020 - 1100	:	Pembentangan Konsep '1Care for 1Malaysia' Oleh : Timbalan Ketua Pengarah Kesihatan (Penyelidikan dan Sokongan Teknikal) Y. Bhg. Dato' Dr. Maimunah A. Hamid
1100 - 1200	:	Pembentangan Pelan Kesihatan Program Kesihatan Awam Oleh : Timbalan Ketua Pengarah Kesihatan (Kesihatan Awam) Y. Bhg. Dato' Dr. Hasan bin Abdul Rahman
1200 - 1300	:	Pembentangan Pelan Kesihatan Program Perubatan Oleh : Timbalan Ketua Pengarah Kesihatan (Perubatan) Y. Bhg. Datuk Dr. Noor Hisham bin Abdullah
1300 - 1400	:	REHAT
1400 - 1430	:	Peserta mengambil tempat
1430 - 1500	:	Majlis Perasmian Oleh : Menteri Kesihatan Y.B. Dato' Sri Liow Tiong Lai

- 1500 - 1530 : Minum Petang
- 1530 – 1630 : Pembentangan Program Pembangunan Modal Insan
Oleh : Timbalan Ketua Setiausaha (Pengurusan)
Y. Bhg. Dato' Ahmad Shafii B Saidin
- 1630 – 1700 : Taklimat Mengenai Garis Panduan Kerja Kumpulan
Oleh : Timbalan Pengarah Kanan (Perancangan)
Dr. Rahimah Mohd Arifin

KUMPULAN KERJA

Kumpulan 1 : Health Sector Transformation (Health Services Delivery)
Pengerusi : Y. Bhg. Dato' Dr. Azmi B. Shafie

Kumpulan 2 : Health Sector Transformation (Governance & Finance)
Pengerusi : Dr. Mohd. Khairi B. Yakub

Kumpulan 3 : Health Awareness & Healthy Lifestyle
Pengerusi : Dr. Rosnah Binti Hadis

Kumpulan 4 : Empowerment of Individual and Community to be Responsible for
their health
Pengerusi : Y. Bhg. Dato' Dr. Hjh Rosnah Bt Hj Ismail

- 1700-2030 : REHAT dan Makan Malam
- 2030-2230 : Bengkel Kerja Kumpulan

3 FEBRUARI 2010 (RABU)

- 0830 - 1030 : Bengkel Kerja Kumpulan
- 1030 - 1100 : Minum Pagi
- 1100 - 1300 : Bengkel Kerja Kumpulan (Sambungan)
- 1300 - 1400 : Rehat dan Makan Tengahari
- 1400 - 1600 : Bengkel Kerja Kumpulan (Sambungan)
- 1600 – 1630 : Minum petang
- 1630 - 1730 : Bengkel Kerja Kumpulan (Sambungan)
- 1730 – 2030 : Rehat dan Makan Malam
- 2030 – 2230 : Perbincangan Jawatankuasa Resolusi
Pengerusi : Y. Bhg. Dato' Dr. Ahmad Razin bin Dato' Ahmad Mahir

4 FEBRUARI 2010 (KHAMIS)

- 0830 - 0945 : Perbincangan Resolusi Persidangan (sambungan)
- 0945 - 10.00 : Minum Pagi
- 10.00 – 10.40 : Pembentangan Resolusi Persidangan RMKe-10
 Pengerusi Panel :
 Ketua Setiausaha Kementerian Kesihatan Malaysia &
 Ketua Pengarah Kesihatan Malaysia
- Ahli Panel :
 Timbalan Ketua Setiausaha (Pengurusan)
 Timbalan Ketua Setiausaha (Kewangan)
 Timbalan Ketua Pengarah Kesihatan (Kesihatan Awam)
 Timbalan Ketua Pengarah Kesihatan (Penyelidikan & Sokongan Teknikal)
 Timbalan Ketua Pengarah Kesihatan (Perubatan)
 Pengarah Kanan Perkhidmatan Farmasi
 Pengarah Kanan Kesihatan Pergigian
- 1040 – 1230 : Perbincangan Panel
- 1230 - 1300 : Ucapan Penutup
 Oleh : Ketua Setiausaha Kementerian Kesihatan Malaysia
 Y.Bhg. Dato' Sri Dr. Hj. Mohd Nasir B. Mohd Ashraf
- 1300 : Makan Tengahari dan Bersurai

APPENDIX 7

LIST OF PARTICIPANTS OF THE TENTH MALAYSIA HEALTH PLAN CONFERENCE

Group TWG 1 : Health Sector Transformation (Health Services Delivery)
Chairman : Y. Bhg. Dato' Dr. Azmi bin Shafie

BIL	NAMA	BAHAGIAN / AGENSI / KEMENTERIAN
1.	Y. Bhg. Dato' Dr. Azmi bin Shafie	Bahagian Perkembangan Perubatan
2.	Dr. Hj. Rohaizat bin Yon	Bahagian Perkembangan Perubatan
3.	En Muhamad Adli bin Mahmood	Bahagian Perancangan dan Pembangunan
4.	Dr. Laili Murni Mokhtar	Bahagian Perkembangan Perubatan
5.	Teo Khian How	Bahagian Khidmat Pengurusan
6.	Dr. Rusni Yusoff	Bahagian Kesihatan Pergigian
7.	Cik Sameerah binti Shaikh Abdul Rahman	Bahagian Amalan dan Perkembangan Farmasi
8.	Abdul Halim bin Abdul Hamid	Bahagian Kejuruteraan
9.	Mohd Amin bin Yaakob	Bahagian Kawalan Perubatan
10.	Dr. Nor Akma Yusuf	Bahagian Perkembangan Perubatan
11.	Dr. Safurah Jaafar	Bahagian Pembangunan Kesihatan Keluarga
12.	Dr. Muhammad Zamri bin Harun	DOSH
13.	Dr. Hasmaizal bin Hassim	DOSH / MOHR / KSM
14.	Dr. Haliza Abd Manaf	JKWPKL & P
15.	Dr. Rohana binti Johan	JKWPKL & P
16.	Dr. Fatimah binti Othman	PKD Johor Bahru

BIL	NAMA	BAHAGIAN / AGENSI / KEMENTERIAN
17.	Dr. Muhammad Hafeezul Suraj Anthony Wilson	MSQH
18.	Ir. Chuan Thong Huat	JKR
19.	Dr. Mary Cardosa	MMA
20.	Prof. Victor K.E. Lim	Academy of Medecine (IMU)
21.	Dato Dr. Mukudan Krishnan	HRPB Ipoh
22.	Dr. Asits Sanna	JKN Sabah
23.	Brig. Jen. Dato' (Dr) Hj. Samsudin Hj. Suirman	Bahagian Perkhidmatan Kesihatan Markas ATM
24.	Prof. Yusuf bin Hussein	Persatuan Farmasi
25.	Dr. Aza Miranda binti Abdul Rahman	Hospital Sungai Buluh
26.	Dr. Amrizan Abd Wahid	Bahagian Perancangan dan Pembangunan
27.	Rosminah Mohd Din	Bahagian Perkhidmatan Farmasi
28.	Dr. Saudah binti Mat Akhir	Bahagian Perancangan dan Pembangunan
29.	Dato' Dr. Kadar Marikar	MSQH
30.	Bariah binti Abdul Rani	Biro Pengawalan Farmasi

Group TWG 2 : Health Sector Transformation (Governance & Financing)

Chairman : Dr. Mohd. Khairi bin Yakub

BIL	NAMA	BAHAGIAN / AGENSI / KEMENTERIAN
1.	Datuk Kamarul Zaman Md. Isa	Bahagian Kewangan
2.	Dr. Rozita Halina Tun Husein	Bahagian Perancangan dan Pembangunan
3.	Wong Foong Lai	Bahagian Kewangan
4.	Dr. Jameela binti Zainuddin	Bahagian Perancangan dan Pembangunan
5.	Dr. Rusilawati Jaudin	Bahagian Perkembangan Perubatan
6.	Adrian Gires	Bahagian Perolehan dan Penswastaaan
7.	Hamilye Sham bin Harun	Unit Komunikasi Koporat
8.	Dr. Mahandran Markandoo	PCDOM
9.	Dr. Zurina Abu Bakar	Bahagian Kesihatan Pergigian
10.	Dr. Elise Monerasinghe	Bahagian Kesihatan Pergigian
11.	Dr. Nour Hannah Othman	Bahagian Perkhidmatan Farmasi
12.	Dr. Norashikin Alias	Bahagian Perancangan dan Pembangunan
13.	N. Vasugi M. Sethu	Bahagian Akaun
14.	Puan Ramlah Daling	Bahagian Akaun
15.	Jamilah Mahmood	Bahagian Kejuruteraan
16.	Farah Wahida Hasim	Majlis Optik Malaysia, Bahagian Amalan Perubatan
17.	Dr. Fariza Mohd Yusof	Cawangan Medikolegal, Bahagian Amalan Perubatan

BIL	NAMA	BAHAGIAN / AGENSI / KEMENTERIAN
18.	Dr. Mathyvani Umapathy	CKAPS
19.	Dr. Mohd Khairi bin Yakub	Jabatan Kesihatan Negeri Johor
20.	Mohamad Fazin Mahmud	Bahagian Penasihat Undang-Undang
21.	Dr. Mohd Rosli Majid	MOD
22.	Dr. Toh Chin Lee	MOH
23.	Nurul Shahida Ahmad	Bahagian Kewangan, KKM
24.	Dato' Dr. Suarn Singh a/l Jasmit Singh	Hospital Bahagia Ulu Kinta
25.	Dr. Mahendran Markandoo	PCDOM
26.	Mohd Dusuki bin Yaacob	Bahagian Kewangan, KKM
27.	Dr. Ghazali Chik	Bahagian Kesihatan Awam, KKM
28.	Dr. Noorazimah Hasan	Bahagian Kesihatan Awam, KKM

Group TWG 3 : Health Awareness & Healthy Lifestyle
 Chairman : Dr. Rosnah binti Hadis

BIL	NAMA	BAHAGIAN / AGENSI / KEMENTERIAN
1.	Dr. Hj. Ahmad Razin bin Dato' Hj Ahmad Mahir	JKN Perak
2.	Dr. Norzila Mohamad Zanudin	Pediatrik
3.	Dr. Salmiah Bustanuddin	Bahagian Kesihatan Pergigian
4.	Puan Norhayati Ali	Bahagian Sumber Manusia
5.	En Zulkifli bin Hamzah	Bahagian Sumber Manusia
6.	Hjh. Nor Aini Abd Wahab	Bahagian Pengurusan Latihan
7.	Dr. Hassan Merican bin Omar Naina	JKN Pulau Pinang
8.	Dr. Noorliza Noordin	Institut Pengurusan Kesihatan
9.	Puan Rokiah Don	Bahagian Pemakanan
10.	Puan Tan Yoke Hwa	Bahagian Sains Kesihatan Bersekutu
11.	Puan Farina Zulkarnain	Bahagian Sains Kesihatan Bersekutu
12.	Hamanyza Ab. Halim	Bahagian Keselamatan dan Kualiti Makanan
13.	Dr. Yaw Siew Lian	Bahagian Khidmat Pengurusan
14.	Dr. Nordin Saleh	Bahagian Perancangan dan Pembangunan
15.	Prof. Dr. Abu Bakar Abdul Majid	Cyberjaya Universiti
16.	Dr. Wan Nazaimoon	IMR
17.	Dr. Zakiah Isnail	IMR

BIL	NAMA	BAHAGIAN / AGENSI / KEMENTERIAN
18.	Puan Ten Sew Keoh	IMR
19.	Dr. S Asmaliza Ismail	NIH
20.	Dr. Jasvinder Kaur	Institut Kesihatan Umum
21.	Dr. Jamaiyah Haniff	CRC
22.	Faridah Aryani Md. Yusof	Bahagian Perkhidmatan Farmasi
23.	Norliza Abu Othman	Bahagian Pengurusan Maklumat
24.	Mohd Zamri bin Selamat	Bahagian Pengurusan Maklumat
25.	Dr. Amiruddin Hisan	Tele-Health
26.	Dr. Dang Siew Bing	Tele-Health
27.	Dr. Fairus Zana Mohd Rathi	BPKK (Primer)
28.	Dr. Md. Khadzir Sheikh Ahmad	Bahagian Perancangan dan Pembangunan
29.	Dr. Ali Munawar	Bahagian Perancangan dan Pembangunan
30.	Izham Harith bin Ikhwan	Bahagian Kejuruteraan
31.	Noriati Baharum	MAMPU
32.	Hasnah binti Saleh	Bahagian Pembangunan Kompetensi
33.	Hasnizam binti Hasan	Bahagian Perkhidmatan Farmasi
34.	Rahayu Shahperi	Bahagian Perubatan Tradisional Komplementari
35.	Dr. Salmiah	Bahagian Khidmat Pengurusan
36.	Dr. Maryana binti Musa	Coordinator
37.	Dr. Hasni binti Md. Zain	Coordinator

Group TWG 4 : Empowerment of Individual and Community to be Responsible for Their Health
 Chairman : Y. Bhg. Dato' Dr. Hjh Rosnah binti Hj. Ismail

BIL	NAMA	BAHAGIAN / AGENSI / KEMENTERIAN
1.	Ab Jabar Ahmad	Bahagian Perkhidmatan Kejuruteraan
2.	Dr. Noor Aliyah binti Ismail	Bahagian Kesihatan Pergigian
3.	Sarene Chu Saifuddin	Bahagian Perkhidmatan Kejuruteraan
4.	Chuah Sot Hoon	Unit Promosi Kesihatan
5.	Fabian Bigar	Bahagian Dasar dan Hubungan Antarabangsa
6.	Ahmad Yusup Che Rus	Kementerian Belia dan Sukan
7.	Khairul Zarina Mohd Yusop	Bahagian Pemakanan
8.	Dr. Jamail Muhi	JKN Sarawak
9.	Dr. Shamsaini binti Shamsuddin	Bahagian Perubatan Tradisional dan Komplementari
10.	Dr. Fauziah Mohd Nor	PKD Bachok Kelantan
11.	Suraiya Syed Mohamed	JKN Selangor
12.	Haji Wan Rokman Wan Yaacob	Bahagian Perkhidmatan Kejuruteraan
13.	Dr. Rosnah Hadis	JKN Selangor
14.	Dr. Rose Nani Mudin	Bahagian Kawalan Penyakit
15.	Abd Manan Mat Dahari	Bahagian Perkhidmatan Kejuruteraan
16.	Surainee Wahab	Bahagian Pemakanan
17.	Lam Kai Kow	Persatuan Farmasi

BIL	NAMA	BAHAGIAN / AGENSI / KEMENTERIAN
18.	Dr. J. Venugopal	Kesihatan Pergigian
19.	Dr. Norliza Ismail	Ass-co-ord
20.	Rissa Soetama	Malaysia Medical Association
21.	Alice Joseph	Malaysia Medical Association

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2.	Dr. Noor Akma binti Yusuff
3.	En Zulkifli bin Hamzah
4.	Dr. Amiruddin bin Hisan
5.	Dr. Lim Kuan Joo
6.	Dr. Azman bin Abu Bakar
7.	En Abdul Jabar bin Ahmad
8.	Puan Siti Sa'adiyah binti Nudin
9.	Dr. Ajau Danis

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