Malaysia: Primary health care key to intersectoral action for health & equity

Case Metadata

MYS--Malaysia_GR_Jaafar-etal_2007-2007

Intersectoral Action Experience Approximate Start Date: Tuesday, June 16, 1970
Intersectoral Action Experience Duration: ~37 years (on-going)

Case Geography

Jurisdiction(s) of Implementation: National government, urban and rural regions (Sabah, Sarawak, Kelantan, Terengganu, Kedah, Pahang and Perlis)
Country: Malaysia

Policy Issue

Policy Issue: In the Malaysia Plan for 1961-1965, the national government identified priority social problems of which poverty was the underlying cause, including health, nutrition, education, environment and social development. In addition, the nation was growing at a rate of 3%, with the potential to double the population in 25 years. Such an increase would "imperil efforts to raise per capita income levels". In addition, in the early 1970s, the rural population made up 60% of the nation's poor. Poverty eradication, particularly in rural and peri-urban communities and disadvantaged ethnic groups, was seen as necessary for a developing multi-ethnic country. Riots in 1969 helped galvanize the national government on these issues. In this case, the policy issue reflected a health gap between urban and rural populations.

Explicitness of Equity: Implicit
Type of Inequality: Gap between two populations
Short Phrase: Rural and peri-urban poverty alleviation and disadvantaged ethnic groups [1]

Policy Solution

Overview: A broad range of healthy public policies were implemented as a part of the National Economic Policies (e.g., New Economic Plan, 1970), which focused on "reducing urban-rural differentials" through primary health care. These policies were implemented in a horizontal, decentralized manner within local community settings in co-ordination with local organizations.

Policy Solution: Distributive [2]

Sector To Whom Implementation of Policy Solution is Accountable: Sectors participating in healthy public policies were accountable to the Ministry of Health.

Instruments for Implementation and Institutional Context: National policy implemented by national and local levels of government.

Financing: The Treasury, a central agency at the national level of government, was responsible for approving and determining the budget allocation for projects and operating/capital funds for policy-implementing ministries.

Program Theory

Strategy: Social programmes employed in Malaysia have addressed health, education, employment, and social protection using a mixture of population strategies (e.g. the Family Medicine
Service, which saw decentralizations of outpatient departments and increased provision of primary health care to health clinics), target group strategies (e.g. a rural health programme was established to deliver health services directly to the rural population), and individual-high-risk strategies (e.g. an immunization programme was made available to all children).

**Category of Main Strategy**: Population strategy/universalism [3]

**Scope of Intervention**: Whole population or universal; rural areas

**Unit Level of Intervention**: Individuals, families and communities [4]

**Social Determinants of Health Entry Point**: Poverty reduction in Malaysia addressed differential exposure to health damaging factors (via nutrition, education, environment, education and infrastructure) and vulnerability of specific groups through a range of primary health care programmes by improving intermediate determinants including living conditions, behaviours or lifestyles as well as access to health and social services.

**Social Determinants of Health Category**: Intermediary: material circumstances [5]

**Summary**: The strategies implemented by the New Economic Plan and subsequent plans were intended to reduce poverty, particularly the disparities between rural and urban population. Primary health care was strengthened as a strategy for health promotion and improved health care access.

**Details on Intersectoral Engagement Process Leading To or Implementing Intersectoral Action**: Yes

**Phase of Policy/Intervention Cycle**: Development or Planning, Implementation, Evaluation

**Main Intersectoral Coordination Mechanisms and Tools Utilized**: The central coordinating agency for healthy public policies is the National Development Council (NDC), which is chaired by the Prime Minister and comprised of selected ministers. The NDC troubleshoots issues in coordinating the implementation of various development projects, with particular attention to poverty reduction projects and those targeted the poor and underserved.

**Institutional Arrangements or Structures for Policy Development**: "The formulation of social policies that address macro social determinants of health involves input from "individual members of the public; interest groups and NGOs; mass media; political parties; federal public service entities, including those at sub-federal levels; the Cabinet; the Parliament (House of Representatives and Senate) and the Paramount Ruler or King", and sometimes, the Council of Rulers. Intersectoral action related to primary health care appears to be coordinated by a bottom-up structure where health and health equity needs are identified at the local and district levels by “situational analyzes” carried out by local governmental staff. Plans to address these needs are then relayed up the structure of government through district and state health officials before taken up by the national Health Ministry for recommendation to other central agencies, including the Treasury within the Prime Minister’s department, which is responsible for decisions about which proposals are funded. Ultimately, this process is centrally coordinated by a National Development Council comprised of various ministers and chaired by the Prime Minister."

**Institutional Arrangements or Structures to Implement Policy Solutions**: The Ministry of Health and Education tend to be the sectors that implement interventions related to health public policies, using at least three levels of organization (i.e., federal, state and district), and in some cases sub-district and village levels within districts to house “service delivery points, i.e., schools and clinics”. For remote rural areas, there may be “mobile clinics” to provide health care.

**Sectors Involved in Leadership**: "Initiation: MI Development: MI Implementation-Evaluation: The health sector takes a leadership role at the local level in assessing the needs of citizens. At the national level, the Ministry of Health leads efforts for healthy public policies by chairing the National Development Council."

**Description of Industry/Private Sector Involvement**: As a part of the "intersectoral mix", the private sector had the opportunity to contribute to policy formation and budget setting for health public policies in Malaysia, as well as in implementing these policies; particularly in the area of poverty reduction for youth. For example, local milk manufacturers worked with the government to develop and implement a School Milk programme to supplement the provision of a safe, healthy, nutritious breakfast for schoolchildren (particularly in rural areas).

**Description of Civil Society Involvement**: Various community groups appear to be engaged in the identification of local health inequities through regular "situational analysis". Various community-based organizations and non-governmental organizations are involved with the formulation, implementation, and evaluation of projects and policies. Non-governmental organizations are also engaged by the Treasury in preparation for the annual budget for public finance.
**Description of Academic Involvement:** Universities were involved in the preparation, campaigning, and implementation of the "Expanded Programme of Immunization" aspect of the Primary Health Care approach.

**Description of Use of Impact Assessment:** No

**Concept of Success of the Policy Solution:** In the most recent plan, the goal for poverty reduction was to halve the incidence of overall poverty to 2.8% and to completely eliminate the incidence of "hardcore poverty" by 2010.

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**Links:**
2. [https://extranet.who.int/isacs/policy-solution/distributive](https://extranet.who.int/isacs/policy-solution/distributive)
3. [https://extranet.who.int/isacs/strategy-type/population-strategyuniversalism](https://extranet.who.int/isacs/strategy-type/population-strategyuniversalism)
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