



MINISTRY OF HEALTH MALAYSIA

# HEALTH WHITE PAPER

Strengthening People's Health,  
Future-proofing The Nation's Health System





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# Abbreviations

APC	Annual Practising Certificate
CPD	Continuing Professional Development
DALYs	Disability-Adjusted Life Years
DPT	Diphtheria, Pertussis, and Tetanus
EMR	Electronic Medical Record
GDP	Gross Domestic Product
GIS	Geographic Information Systems
GP	General Practitioner
HIES	Household Income and Expenditure Survey
HWP	Health White Paper
ICT	Information and Communication Technology
IT	Information Technology
KPI	Key Performance Indicators
LHR	Lifetime Health Record
MMR	Maternal Mortality Rate
NCDs	Noncommunicable diseases
OOP	Out of Pocket
PeKa 40	<i>Peduli Kesehatan untuk Kumpulan B40</i>
SDG	Sustainable Development Goals
SDH	Social Determinants of Health
SOP	Standard operating procedure
TB	Tuberculosis
UHC	Universal Health Coverage
WHO	World Health Organisation

# Terminology

## Health system

Ecosystem of health and health-impacting services which include but are not limited to healthcare services, social care services, community outreach services and others.

## Healthcare system

The system by which people obtain the health care they need, for example consultation and treatment services from clinics or hospitals, health screening services, and others.

## Public Health<sup>1</sup>

Public health refers to all organised measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases

## Primary health care (PHC)<sup>2</sup>

Primary health care is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and across life course along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, and as close as feasible to people's everyday environment.

PHC entails three interrelated and synergistic components, including: comprehensive integrated health services that embrace primary care as well as public health goods and functions as central pieces; multi-sectoral policies and actions to address the upstream and wider determinants of health; and engaging and empowering individuals, families, and communities for increased social participation and enhanced self-care and self-reliance in health.

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1 WHO, Public Health Factsheets

2 WHO, Primary Health care Factsheets

### **Secondary health care<sup>3</sup>**

Secondary health care is the specialist treatment and support provided by doctors and other health professionals for patients who have been referred to them for specific expert care, most often provided in hospitals.

### **Tertiary health care<sup>4</sup>**

Tertiary health care has been defined as highly specialised medical care, usually provided over an extended period, that involves advanced and complex diagnostics, procedures and treatments performed by medical specialists in state-of-the-art facilities.

### **Fund/Risk pooling**

The accumulation of a pool of funds for health on behalf of a population in order to redistribute risk so that care received is based on need foremostly, not capacity to pay.

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3 New World Encyclopaedia. Health Care - Secondary Care

4 Merriam-Webster Dictionary. Definition of Tertiary Care

# Chronology of Health

The development of the Health White Paper incorporates input and Health including the people through engagement sessions, town hall, conferences health system.

61 engagement sessions (Focused Group Discussions) was conducted involving 7,981 stakeholders from various categories to develop health reform strategies.

Started getting technical input from 3 international consultants

The Cabinet approved the development of the health white paper.

The official website of the White Paper on Health ([www.moh.gov.my/kertasputihkesihatan](http://www.moh.gov.my/kertasputihkesihatan)) was launched to share information and get people's views.

February 2022 - June 2023

1 April 2022

5 April 2022

17 April 2022



Health White Paper Draft Finalization Workshop.

9 Town Hall sessions was conducted according to zone throughout Peninsular Malaysia including Sabah & Sarawak.

Engagement session with 33 media editors to provide detailed on the Malaysia health system reform.

25- 26 August 2022

18 April - 19 May 2023

30 May 2023



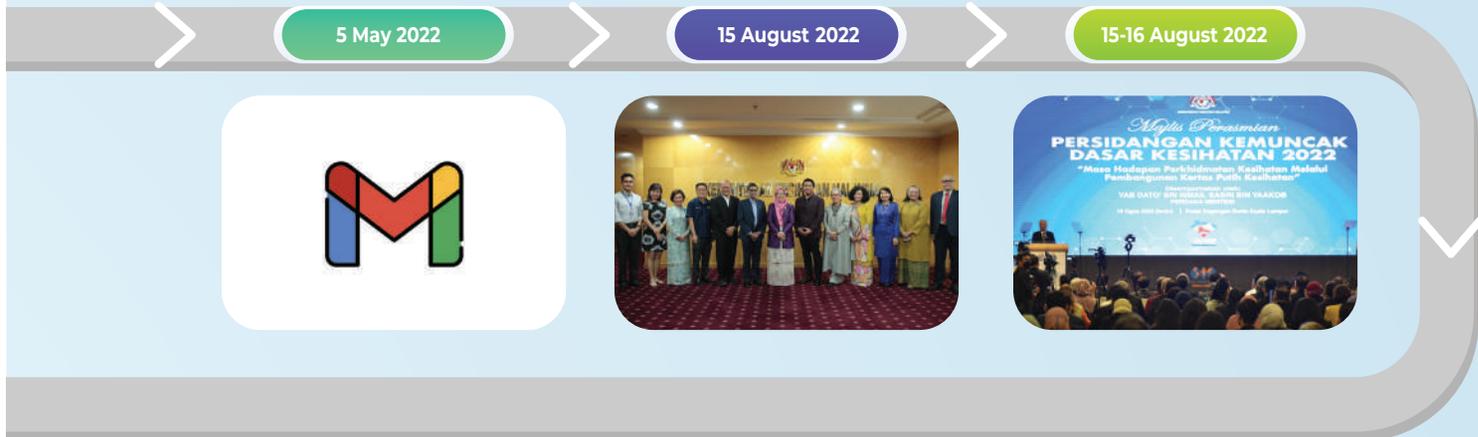
# White Paper Development

suggestion from various stakeholders, both within and outside the Ministry of and briefing as well as recommendations from previous studies related to the

The official Health White Paper email (kertasputihkesihatan@moh.gov.my) was created to receive input from various stakeholders.

The establishment of the Health White Paper Advisory Council consisting of 13 health and non-health experts.

The 2022 Health Policy Summit themed "The Future of Our Health Care - Health White Paper Development at WTC, KL.



Engagement session with Members of Parliament

Health White Paper was tabled and passed by the Dewan Rakyat with bipartisan majority support

Health White Paper was tabled in the National Dewan Negara



# Executive Summary

The Health White Paper for Malaysia (HWP) aims at reforming the nation's health system towards realising better health and well-being for the people. While Malaysia has achieved relatively good health outcomes since Independence, the health system today is straining to cope with a significantly different set of challenges that has emerged in recent decades. The HWP sets out a holistic proposal for systemic and structural reforms of the Malaysian health system in order to respond to the nation's health challenges and to ensure greater equitability, sustainability and resilience of the health system.

**Chapter 1** overviews the health trends, challenges and gaps in Malaysia. Healthcare in Malaysia has been acknowledged globally as one of the best health systems amongst its peers that provide effective health services. Nevertheless, with the passage of time, health challenges driven by social and environmental factors such as the rising burden of non-communicable diseases, the emergence and re-emergence of communicable diseases, and the ageing population are some of the growing concerns. In addition, challenges driven by the country's health system's characteristics and other systemic factors, as well as advances in healthcare, have created greater needs and expectations for healthcare services from the people.

The public and private health sectors in Malaysia are dichotomous and not integrated in terms of service delivery and resources for health resulting in an imbalance of burden on facilities and human resource especially in the public sector. Healthcare expenditure is also on the rise in line with increasing demand and needs of the people, coupled with the escalating cost of providing healthcare services.

**Chapter 2** outlines the purpose and scope of the HWP as well as aspirations for the health system. The purpose of the HWP is to propose a major and holistic health reform to ensure it is equitable, sustainable, and resilient, and serves the needs of all individuals at all stages of life. HWP will be the main policy document and focuses on system-wide reforms to address the most pressing and longstanding needs of the health system. These vital changes require long-term commitment and support from all major stakeholder groups in the country. The HWP will be tabled to the Malaysian Parliament in order to secure bipartisan support for the significant work that lies ahead. Further details in terms of planning and implementation of the strategies in HWP will be detailed in the next phase after getting approval in Parliament.

Based on the needs assessment of several systemic studies as well as stakeholder engagement sessions, the HWP proposes the following aspirations for the nation's health system:

- **A healthy nation**, with a conducive ecosystem so that the younger generation is more aware and prioritises the need to be healthy. Emphasis will be given towards preventive and promotional services so that all walks of life will adopt a healthier lifestyle.
- **An equitable, accessible and person-centred health system**, where people have reasonably easy access to good quality, affordable health services and in which services are designed around a person's living situation.

- **A resilient health system**, which is able to anticipate and respond to demands from known health challenges such as NCDs as well as rapid health emergencies such as outbreaks and pandemics.
- **An open and innovative health ecosystem**, incorporating technological advances and latest innovations in delivery of health services so that they are more efficient and effective.
- **A health system prized and valued by the people**, continuously improved to be more equitable, accessible and resilient.

**Chapter 3** describes the four pillars of health system reform. It presents the foundational building blocks of Malaysia's health system and outlines the opportunities for system-level improvements as follows:

### **Pillar 1: Transforming healthcare service delivery**

The health system reform will prioritise transforming primary health care (PHC) by increasing investment and reallocating more resources, especially on funding, human resources, facilities and health equipment availability. This approach will be cost-effective, generate efficiencies, and deliver health improvements using fewer resources than alternative arrangements. The reformed primary health care aspires towards person-centred care and bringing care nearer to the community. Primary health care teams will be responsible for monitoring the health status of a designated population and cultivating long-term patient-doctor relationship. The PHC teams can be from both public or private sector health service providers.

The nation's hospital services, mainly the public sector, will focus on optimising hospital care services to achieve better efficiency, performance and quality. The hospital services will be reoriented to focus on acute and complex care management. Ambulatory care sensitive conditions, better addressed in PHC and community settings, will be progressively shifted out of hospital settings. Transitional care management will be placed at the community level to ensure patient management continuity after treatment completion at the hospital, reducing the load in hospital settings.

Intersectoral public and private partnerships will be enhanced to help to balance resource utilisation across the public, private and non-profit sectors. Through this, healthcare services will be widened, public healthcare facilities will be less crowded, waiting time will be reduced, particularly for high-demand procedures, and healthcare services will be brought closer to the people. Besides, effective coordination between sectors and agencies, including NGOs across healthcare and non-health care providers, will be implemented as part of the whole-of-nation approach in addressing health as well as social determinants of health.

Integrating digital technologies into the nation's health systems will be bolstered by strengthening the resourcing and implementation of key digitalisation projects. Electronic medical records (EMR) and electronic lifetime health records (ELHR) will be rolled out in stages, containing the individual's health status, medical history and other relevant information. The quality and continuity of care across different health providers and levels of care will also be significantly improved with the implementation

of telehealth. A broad range of settings from rural clinics to long-term care facilities will be able to provide health care services with better access and reduce the need for physical attendance at PHC facilities through digitalisation initiatives.

New approaches to resource allocation, planning and monitoring will be put in place in order to ensure vulnerable groups receive sufficient healthcare and systemic inequalities in health are addressed. Policy and operational review will be undertaken in order to strengthen access and quality of care for vulnerable groups such as the older person groups, Orang Asal, persons with disabilities, persons living with or at risk of HIV, victims of domestic violence and abuse, non-citizens which include the undocumented, the stateless, migrant workers, refugees, and asylum seekers, as well as other groups in need of support or protection. Current platforms and pathways for coordination with relevant ministries and community groups will also be strengthened towards addressing the health needs of the vulnerable and marginalised groups.

## **Pillar 2: Advancing health promotion and disease prevention**

In this reform, there will be a new focus on moving away from simply treating ill people to a new paradigm of ensuring people stay healthy. Health promotion and disease prevention approaches will be ingrained and practised at all levels in the nation to provide a health system where the people will be empowered to maintain, protect and improve their health. Digital health technologies will be prioritised to improve data collection, analysis, and monitoring, enhancing the ability of government agencies to strengthen the country's health emergency preparedness and response efforts and drive more evidence-based public health practices.

The COVID-19 pandemic has highlighted the importance of improving public health and emergency preparedness functions. A sustained effort, including regular assessments, training, and funding, especially in cross-agency and cross-boundary coordination, will ensure that systems are continually improved and adapted to changing circumstances. An interagency task force will be established to coordinate health in all policies and facilitate communication among government agencies by leveraging cross-agency committees that monitor the achievement of the United Nations Sustainable Development Goals (SDGs) to address social determinants of health (SDH) and health equity. A whole-of-society approach involving different stakeholders will be developed to support this approach further.

Applying incentives and disincentives will help to acculturate healthy behaviours and norms by influencing individual and collective behaviour change. Incentives will include financial and non-financial rewards to improve physical activity, nutrition, health screening and personal monitoring of health status like target subsidies for low-income and vulnerable groups and public campaigns. Disincentives, such as taxes on unhealthy products and public health regulations to safeguard safety standards will be fortified to deter unhealthy behaviours and reinforce the importance of healthy choices.

### **Pillar 3: Ensuring population receive comprehensive services that are affordable**

Malaysia is currently under-investing in health and it does not match the increasing demand of current and future needs. There is a great need to increase investment into the health system in order to realise the much-needed reform while taking into account the Government's position and fiscal capacity.

The Government's role in this aspect is important to attain Universal Health Coverage and protect individuals from financial risk when they fall ill. Publicly managed health funding from various sources including the Government, individuals and companies needs to be gradually increased to 5% of GDP. This increment will also take into account strategic collaboration and the use of resources and assets across various stakeholders.

To better target health care subsidies, the current fee structure in public healthcare facilities will be revised, with payments to commensurate ability to pay. This ensures equity in financing while preserving the affordability of health care services for lower income and vulnerable households. Besides that, to diversify sources of funding, options for a progressive contributory scheme will also be explored to ensure the sustainability of health financing.

A benefit package will be developed, outlining a specified list of services and medications that can be accessed by the population in both the public and private sectors, at an affordable fee. The benefit package will be financed by a dedicated health fund under the management of not-for-profit Strategic Purchaser, governed by clear reporting standards and robust regulatory oversight. This arrangement allows for greater pooling of health and financial risks within the population, thus contributing towards a reduction in out-of-pocket spending and incidence of catastrophic health expenditure.

The role of the Strategic Purchaser will be fortified to enable procurement of health care services from both public and private sectors through innovative and value-based payment models. Allocative efficiency will be improved by focussing health resources towards more cost-effective interventions, with an emphasis on primary healthcare. In addition, scaling up digitalisation and increasing autonomy of public health facilities will contribute towards greater financial and operational efficiencies.

### **Pillar 4: Strengthening the health system's foundation and governance**

The role of the MOH will be strengthened by placing greater focus and improving its role in governance, oversight and stewardship of the health system. The role of MOH as a provider and purchaser of health services will be gradually devolved to improve service delivery performance and check and balance function. Public sector facilities will continue to play the role of service providers while the responsibility of purchasing health services from both public and private sectors will be carried out by the Strategic Purchaser.

Existing health-related policies, legislation and regulations will be improved based on current and future needs as well as challenges faced by the health system. Revisions to policies, legislation and regulations will be carried out with consideration and inputs from all relevant stakeholders.

Fortifying the health workforce is pivotal and the reform will focus on education and training, licensing and registration, public sector recruitment, deployment, development and retention, as well as community health workforce. Education and training will be restructured to improve education standards and in-service training of the various professions. The public sector recruitment process will be comprehensively reviewed to meet current and future needs. Collaboration and partnership with various stakeholders will be intensified to develop a framework for multi-sectoral cooperation and improve coordination among the formal and the broader community health-related health workforce.

Stimulating research, innovation, and evidence-based approaches are essential for advancing the health system to be more effective and efficient over time. It includes investments in skilled workforce, infrastructure and technology to increase research and innovation capacity. Research and analytics will also support in improving the efficiency and cost-effectiveness of health spending, inform policy-making as well as strengthen governance and stewardship functions to drive continuous improvement in population health outcomes sustainably.

**Chapter 4** describes the long-term planning of the health system reform, which will be implemented in consecutive phases. It will be implemented through broad sequencing and estimated time horizons associated with the key reform strategies and initiatives proposed in the HWP.

The short-term horizon or the first five years of health system reform will focus on laying the foundational building blocks that will enable the multi-year implementation of complex systemic or structural reforms. The medium-term horizon, or the middle five years of health system reform, will see the next stage roll out and expansion of initiatives beginning earlier. The long-term horizon or the latter five years of health system reforms will see a transition towards stabilisation. Initiatives to refine or course-correct earlier work can be expected, but the fundamental shifts in the health system's direction, priorities and organisation would have begun to take shape.

**Chapter 5** explains the need for the establishment of an independent monitoring body to monitor, analyse and report the status as well as submit recommendations and suggestions where necessary during the implementation process of health reform. This body will establish a check and balance mechanism while ensuring stability of the health reform reporting process in the political economy environment throughout the reform period and ensure commitment to long-term health reform.

**Chapter 6** concludes the need for the Malaysian Health System to undergo reforms in order to be resilient and future-proofed. All the reform efforts suggested in the Health White Paper are conceptual and detailed implementation plans will be fleshed out in the next phase. Adjustments and adaptations of the reform process will be made in accordance with the situation and also considering inputs from the Government, independent reform monitoring body or Parliamentary Select Committee once tabled and debated in Parliament.

In conclusion, there is an urgent need to reform the health system in order to address current and future health challenges and needs as well as to improve the wellbeing and enable Malaysians to live healthier. Before more time is lost, Parliament, people and the nation must stand together and begin the journey of health system reform today.





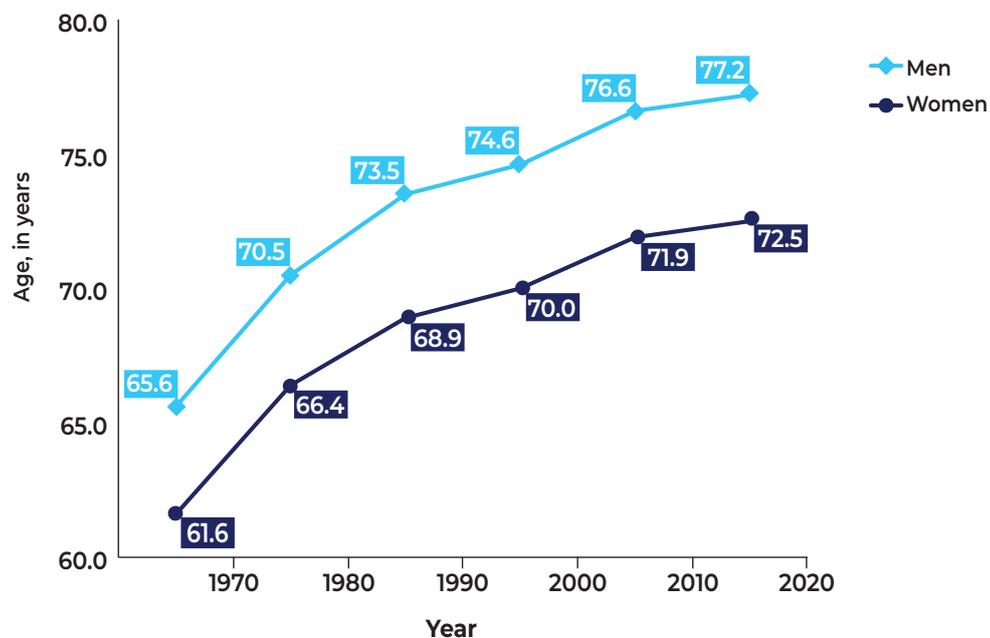
# Chapter 1

## Issues and Challenges of the Health System

### 1.1 Introduction

Since Independence, Malaysia has achieved relatively good health outcomes, broad health services coverage and reasonably widespread financial risk protection. However, in the last two decades, the health status of the people has been declining.

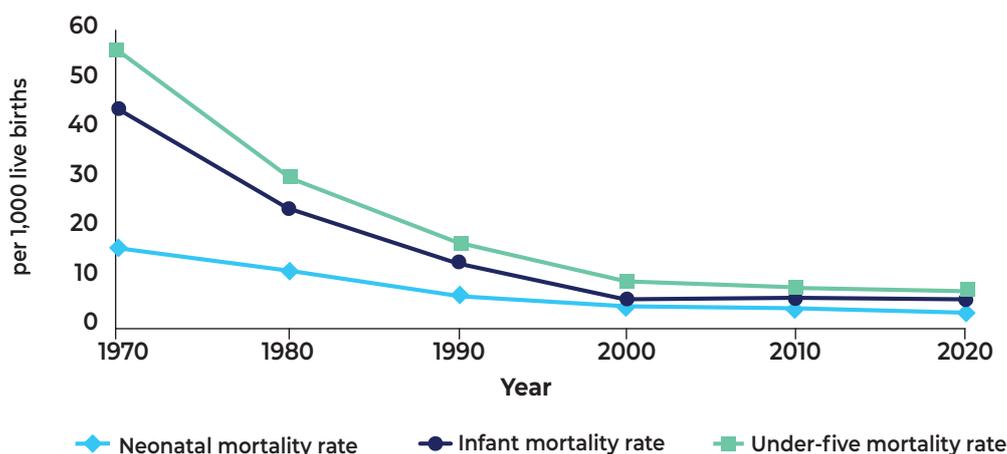
Malaysians are living longer. A male and female baby born in 1970 would live to the age of 61.6 and 65.6 years old on average, respectively. In 2020, a male and female newborn respectively can expect to live to the age of 72.5 and 77.2 years old on average. As shown in Figure 1 below, the average life expectancy of the Malaysian population has been steadily increasing over the decades.



**Figure 1:** Life expectancy at birth, Malaysia, 1970-2020

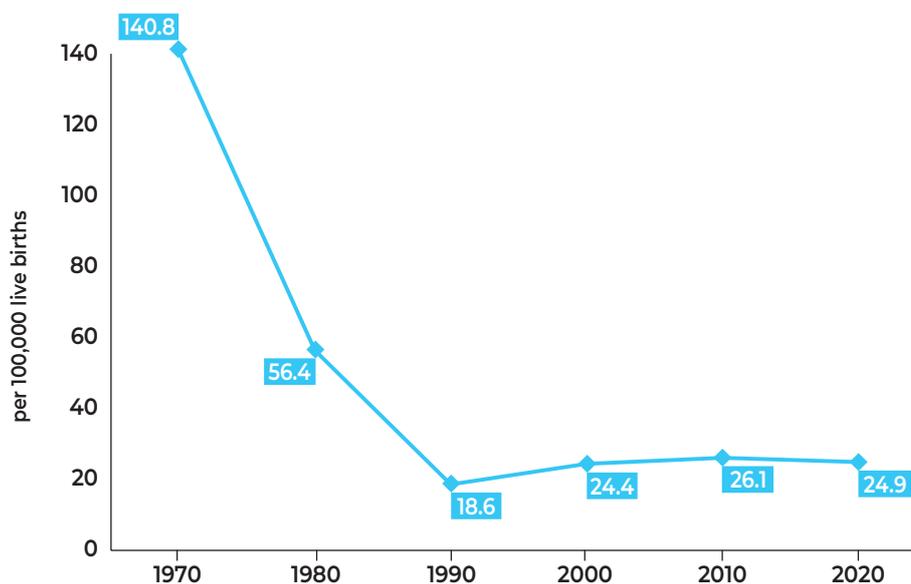
Source: Department of Statistics, Malaysia (2020)

The increase in life expectancy is accompanied by a significant decrease in mortality rates, including in the important indicators of child and maternal mortality. The number of deaths among infants aged less than 28 days, or the neonatal mortality rate, stood at 3.9 deaths per 1,000 live births in 2020 compared to 16 deaths per 1,000 live births in 1970 (Figure 2). Similar declines were recorded in the infant mortality rate<sup>1</sup> as well as the under-five child mortality rate<sup>2</sup> which stood at 5.9 deaths per 1,000 live births and 7 deaths per 1,000 live births respectively as of 2020 (Figure 2). The number of maternal deaths also declined, from 140.8 deaths per 100,000 live births in 1970 to 24.9 deaths per 100,000 live births in 2020 (Figure 3).



**Figure 2:** Infant and child mortality rates, Malaysia, 1970-2020

Source: Department of Statistics, Malaysia (2020)



**Figure 3:** Maternal mortality rates, Malaysia, 1970-2020

Source: Department of Statistics, Malaysia (2020)

1 Number of deaths among infants under 1 year old

2 Number of deaths among children under 5 years old



Due to a convergence of factors however, the health system today, particularly the public healthcare system, is indisputably overstretched, overburdened, and dated. Apart from ensuring that gains in long-standing health outcomes such as maternal and child mortality are maintained, the country's health system must also address a significantly different set of health challenges in recent decades brought on by changes in income, lifestyle, urbanisation, and planetary health. These challenges have imposed considerable operational and financial strain on the nation's health system, resulting in large gaps that became extremely evident during the peaks of the COVID-19 pandemic in 2020 and 2021.

The COVID-19 pandemic has powerfully shown the vital contribution of health to all aspects of the nation's fabric, from the economy to social well-being to national security, and the imperative for a high-performing health system. The Health White Paper (HWP) sets out a holistic proposal for systemic and structural reforms in order to respond to the nation's health challenges in a manner that ensures greater equitability, sustainability, and resilience of the Malaysian health system.

## THE CONTRIBUTION OF THE HEALTH SYSTEM IN VARIOUS ASPECTS



Economy



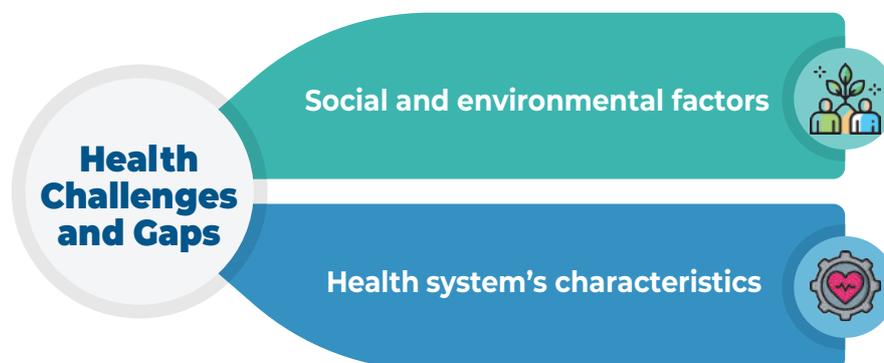
Social Well-being



National Security

## 1.2 Malaysia's Health Challenges and Gaps

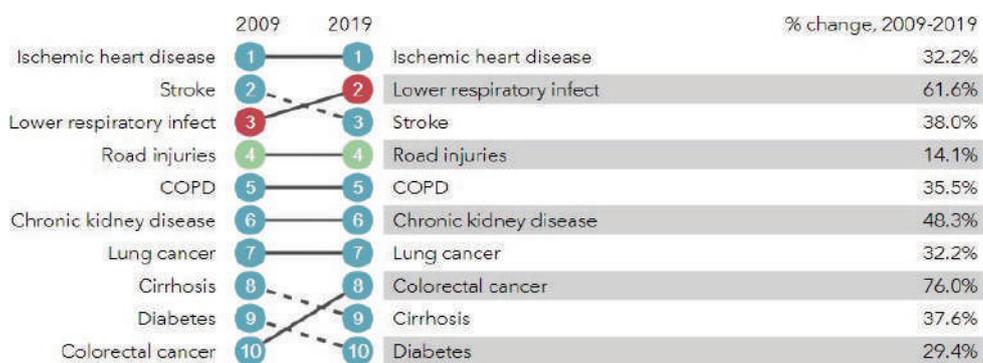
The nature of Malaysia's health challenges and gaps can be grouped into two broad categories: health challenges driven by social and environmental factors and challenges arising from the health system's characteristics.



### 1.2.1 Challenges driven by social and environmental factors

#### (a) Rising burden of noncommunicable diseases

Noncommunicable diseases (NCDs), also known as chronic diseases, have become the leading cause of death<sup>3</sup> and disease burden<sup>4</sup> in Malaysia. The most common causes of mortality over the past decade are related to NCDs such as cardiovascular diseases (heart disease and stroke), chronic respiratory diseases, cancer, and diabetes (Figure 4).



**Figure 4:** Top 10 causes of total number of deaths and percentage change from 2009-2019, all ages combined<sup>5</sup>

Source: The Institute for Health Metrics and Evaluation (2020)

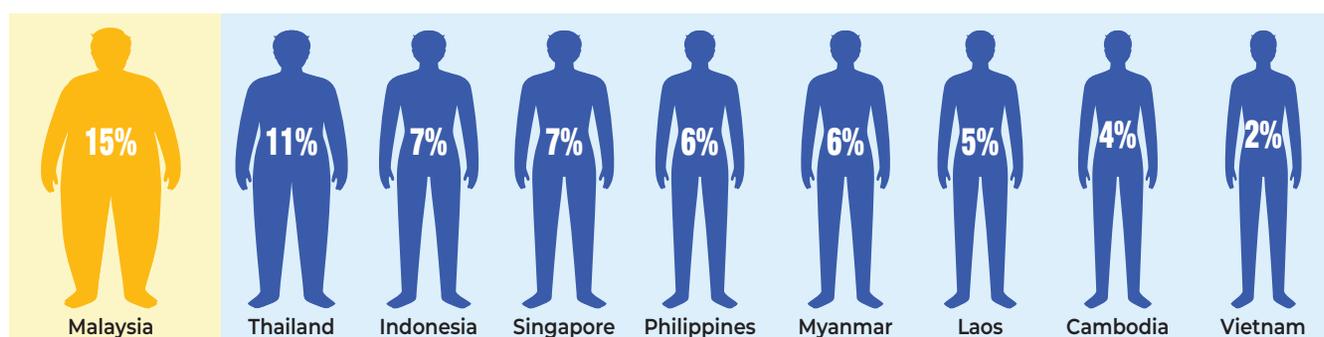
3 Department of Statistics Malaysia (2021). Statistics on Causes of Death, Malaysia.

4 Institute for Public Health (2020). National Health and Morbidity Survey (NHMS) 2019: Non-communicable diseases, healthcare demand, and health literacy—Key Findings

5 Though it does not appear in this chart due to population averaging, it should be noted that breast cancer is one of the top causes of death for women

Similar to other countries globally, the rising incidence of NCDs in Malaysia is driven by lifestyle-related risk factors such as physical inactivity, tobacco use, substance abuse, harmful use of alcohol and an unhealthy diet. Approximately 98% of Malaysian adult have or are affected by at least one NCD risk factor<sup>6</sup>. These risk factors are partly attributable to underlying circumstances such as rapid urbanisation, the design of living environments, income inequalities<sup>7</sup>, lack of nutrition-related regulations, increased pollution and deteriorating planetary health, low health literacy and many other social and environmental determinants.

Obesity is a strong signal of NCD incidence and alarmingly, Malaysia is the country with the highest prevalence of obesity<sup>8</sup> in Southeast Asia (Figure 5).



**Figure 5:** Percentage of adult population with obesity<sup>139</sup> in Southeast Asia, 2018

Source: Non-communicable diseases country profile, World Health Organisation (2018)

Beyond the alarming rise in NCDs, the challenges faced by NCD control programmes are exacerbated by lack of awareness, delays in diagnosis and poor adherence to interventions. Many cases of NCDs go undiagnosed in its early stages; nearly half of the population are unaware of having diabetes or hypertension<sup>10</sup>. Malaysians from lower income quintiles and Malaysians from rural areas are more likely to have undiagnosed NCDs<sup>11</sup>.



6 Atun R, Berman P, Hsiao W, Myers E, Wei AY. (2016). Malaysia Health System Research (MHSR) Volume 1 - Contextual analysis of the Malaysian health system. Boston, Massachusetts: Harvard TH Chan School of Public Health.

7 Ismail, N. W., & Sivadas, S. (2020). Urban health and the prevalence of non-communicable diseases in Malaysia. *Malaysian Journal of Medicine and Health Sciences*, 16(2), 3-9.

8 World Health Organization. (2018). Noncommunicable diseases country profiles 2018. World Health Organization. Available at <https://apps.who.int/iris/handle/10665/274512>. Access on 24/09/2022

9 Adult obesity comprises individuals 18 years old and above with BMI of 30 kg/m<sup>2</sup> or more

10 Institute for Public Health (2020). National Health and Morbidity Survey (NHMS) 2019: Non-communicable diseases, healthcare demand, and health literacy—Key Findings

11 Ibid 10

The rising rates of NCDs in chronic stages have increased the cost of care per patient significantly due to the cost of treatment and prescription drugs as well as the cost of management of long-term complications such as cardiovascular and chronic kidney diseases. Beyond the direct cost of care, NCDs also cause losses in economic productivity estimated at nearly 1% of gross domestic product (GDP)<sup>12</sup>.

## The rising rates of NCDs have increased the cost of care per patient significantly due to the cost of treatment



### (b) Emergence and re-emergence of communicable diseases.

The current COVID-19 pandemic has been the signal health event in modern times, eclipsing previous global outbreaks of communicable disease such as SARS, H1N1 and MERS-COV in scale and intensity. COVID-19 has been the worst infectious disease outbreak in Malaysia since the Spanish Flu in 1918, causing 36,387 deaths at the time of writing compared to 34,644 deaths in then British Malaya<sup>13</sup>.

Based on the rate of pathogen spread over the past 50 years, recent studies estimate increasing probabilities and frequency of novel disease outbreaks in the next few decades<sup>14</sup>. Population growth, changes in food systems, planetary degradation and urbanisation are important driving factors, contributing to zoonotic spill overs or the transmission of pathogens from wild animals to humans, which account for an estimated 60-75% of pandemics and infectious disease outbreaks<sup>15</sup>.

In addition to novel communicable diseases, there is also a worrying re-emergence of known communicable diseases such as measles, tuberculosis, and HIV. Persistent communicable diseases such as dengue also continue to

**Factors driving the resurgence of infectious diseases include vaccine hesitancy, microbial adaptation, antimicrobial resistance, increased human susceptibility to infection, demographic and behaviour changes, environmental, urbanization and social inequality.**

12 The Impact of Noncommunicable Diseases and Their Risk Factors on Malaysia's Gross Domestic Product (2020). Putrajaya, Malaysia: Ministry of Health Malaysia.

13 Hashim, J. H., Adman, M. A., Hashim, Z., Radi, M. F. M., & Kwan, S. C. (2021). COVID-19 epidemic in Malaysia: epidemic progression, challenges, and response. *Frontiers in public health*, 9.

14 Marani, M, Katul G.G., Pan, W.K., Parolari, A.J. (2021). Intensity and frequency of extreme novel epidemics. *Proceedings of the National Academy of Sciences (PNAS)*.

15 Ellwanger, J. H., & Chies, J. A. B. (2021). Zoonotic spillover: Understanding basic aspects for better prevention. *Genetics and Molecular Biology*, 44.

present a significant burden to the health system. Numerous interweaving factors are driving disease re-emergence including vaccine hesitancy, microbial adaptation, antimicrobial resistance, increased human susceptibility to infection, evolving human demographics and behaviour, the urban built environment, social inequality, and many others<sup>16</sup>.

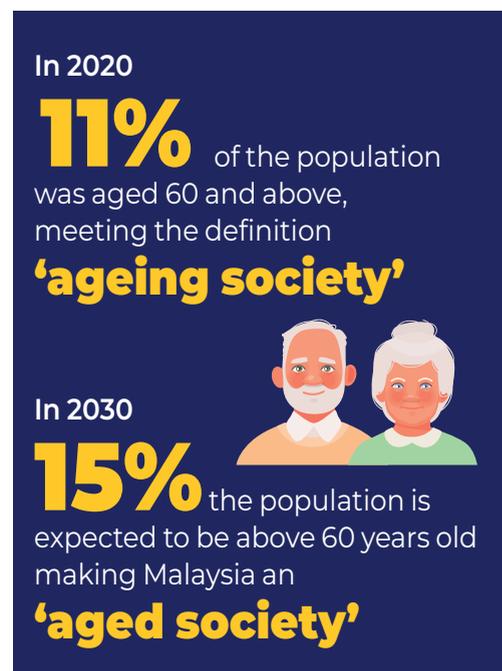
The emergence and re-emergence of communicable diseases has put renewed pressures on the country's public health function, outbreak response mechanisms and treatment capacity, as clearly seen in the overextended utilisation of public hospitals, isolation centres and primary health clinics during the peaks of the COVID-19 pandemic.

### (c) Ageing population

Since 2015, and for the first time in Malaysia's history, the proportion of older persons in the population is higher than the proportion of children below 5 years old<sup>17</sup>. In 2020, more than 11.2% of the population was aged 60 and above, meeting the definition of an 'ageing society'. By 2030, 15% of the population is expected to be above 60 years old making Malaysia an 'aged' society<sup>18</sup>.

Even though Malaysians are living longer, the population is not necessarily living in better health. Based on current trends, an estimated 9.5 years of life expectancy will be spent in poor health due to the incidence of NCDs or chronic diseases<sup>19</sup>.

As the number of older persons with chronic diseases increases, so will the demand for long-term care. Especially for management of neurological diseases, will require appropriate expertise in health and social care services. It is estimated that healthcare utilisation for older persons will cost 2-3 times more per year compared to younger age groups<sup>20</sup>.



16 Raslan R, El Sayegh S, Chams S, Chams N, Leone A and Hajj Hussein I (2017) Re-Emerging Vaccine Preventable Diseases in War-Affected Peoples of the Eastern Mediterranean Region-An Update. *Front. Public Health* 5:283.

17 Population Ageing: Can We "Live Long and Prosper"? (2015). Khazanah Research Institute.

18 Nik Norliati F, Suriati G (2021). Malaysia towards an ageing society. *Malaysia Journal of Society and Space*.

19 Social Inequalities and Health in Malaysia: The State of Households 2020 Part III. Khazanah Research Institute. (2020)

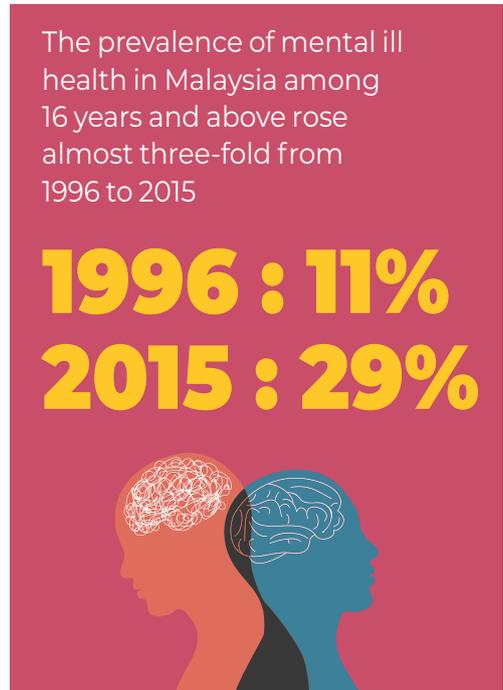
20 24 Kasteridis, P., Street, A. D., Dolman, M., Gallier, L., Hudson, K., Martin, J., & Wyer, I. (2014). The importance of multimorbidity in explaining utilisation and costs across health and social care settings: evidence from South Somerset's Symphony Project.

#### (d) Impact of mental health

Mental health issues are one of the highest contributors to the burden of non-communicable disease and disability in Malaysia. The prevalence of mental ill health in Malaysia was estimated at 29.2% among 16 years and above in the population in 2015, rising almost three-fold from an estimated 10.7% of the same age group in 1996<sup>21</sup>.

The most common factors associated with mental health issues are related to financial constraints, family issues, career problems and prolonged stress from the workplace<sup>22</sup>. More recently, the COVID-19 pandemic also had a significant impact on the population's mental health<sup>23</sup>.

In addition to the suffering endured by those afflicted, mental ill health also has a significant impact on the economy, costing an estimated RM3.28 billion in absenteeism and RM9.84 billion for presenteeism<sup>24</sup>. According to the World Health Organization (WHO), mental ill health costs the global economy USD 1 trillion annually from the loss of productivity with depression being the leading cause of mental illness<sup>25</sup>.



#### (e) Climate change and the deterioration of planetary health

The effects of climate and ecological change have resulted in increasingly frequent and severe extreme weather events, rising sea levels and habitat destruction across geographies. These changes have profound impacts on human life including increasingly fragile food supplies, heightened vulnerability for coastal populations, and increased risk of the spread of pathogens.

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- 21 Institute for Public Health (2020). National Health and Morbidity Survey (NHMS) 2019: Non-communicable diseases, healthcare demand, and health literacy - Key Findings
  - 22 Hassan, M. F. bin, Hassan, N. M., Kassim, E. S., & Hamzah, M. I. (2018). Issues and Challenges of Mental Health in Malaysia. *International Journal of Academic Research in Business and Social Sciences*, 8(12), 1685–1696.
  - 23 Balakrishnan, V., Ng, K. S., Kaur, W., & Lee, Z. L. (2022). COVID-19 mental health prevalence and its risk factors in South East Asia. *Current Psychology*, 1-16.
  - 24 Chua, S. N. (2020). The economic cost of mental disorders in Malaysia. *The Lancet Psychiatry*, 7(4), e23.
  - 25 Bubonya, M., Cobb-Clark, D. A., & Wooden, M. (2017). Mental health and productivity at work: Does what you do matter? *Labour Economics*, 46, 150–165.

A major effect of climate change for Malaysia is the increased frequency and severity of flooding<sup>26</sup>. Apart from the effect on livelihoods and property, flooding increases the risk of waterborne and vector-borne diseases. The effects of such diseases as well as other impacts from climate change such as heat waves and air pollutants will affect overall health outcomes, particularly amongst older persons who are likely to have existing health conditions and compromised immune systems<sup>27</sup>.

The air and water pollution in our environment also has a negative impact on health. Globally, pollution is responsible for 21% of all cardiovascular disease deaths, 26% of ischemic heart disease deaths, 23% of stroke deaths, 51% of deaths from chronic obstructive pulmonary disease, and 43% of lung cancer deaths. Anxiety and depression associated with climate change events such as heat waves, recurrent floods, forest fires and other phenomenon are also on the rise particularly amongst young people<sup>28</sup>.

## **1.2.2 Challenges arising from the health system's characteristics**

### **(a) Dichotomous service delivery by the public and private sectors**

Malaysia has a hybrid healthcare system, comprising a public healthcare system<sup>29</sup> and the private healthcare system. These two sectors usually operate separately, however the public sector has done several outsourcing programs with the private sector especially during the COVID-19 pandemic. The public sector seeks to provide widespread coverage of universal healthcare for the population, delivering virtually near-free primary healthcare services and heavily subsidised secondary and tertiary care services which is largely funded by federal government revenues. The private sector seeks to provide healthcare services to the public on a fee-for-service basis which is predominantly funded by individual out-of-pocket payments and private health insurance, the latter including employee benefits (Figure 6).

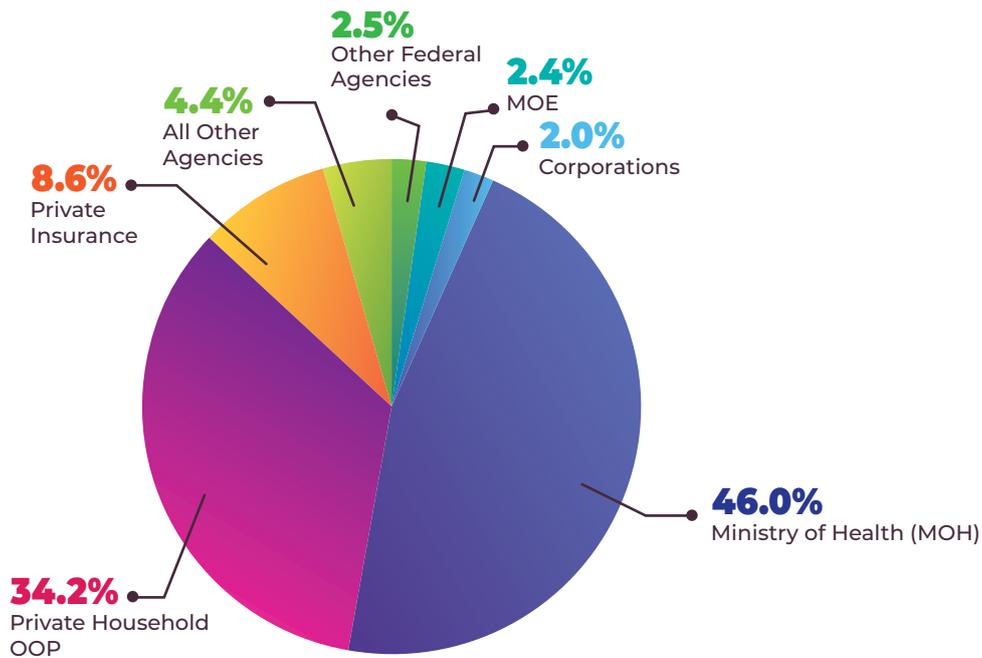
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26 Chan, N. W. (1997). Increasing flood risk in Malaysia: causes and solutions. *Disaster Prevention and Management: An International Journal*.

27 Watts, N., Amann, M., Arnell, N., Ayeb-Karlsson, S., Beagley, J., Belesova, K., ... & Costello, A. (2021). The 2020 report of the Lancet Countdown on health and climate change: responding to converging crises. *The Lancet*, 397(10269), 129-170.

28 Sharpe, I., & Davison, C. M. (2021). Climate change, climate-related disasters, and mental disorder in low-and middle-income countries: a scoping review. *BMJ open*, 11(10), e051908.

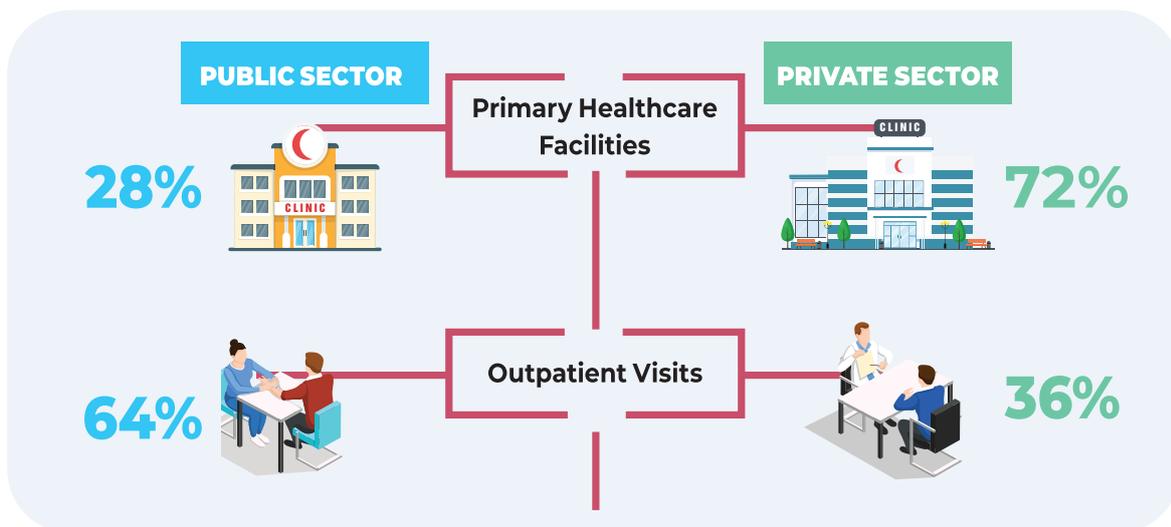
29 Number of hospitals operated by Ministry of Health, 146; Ministry of Education, 5; Ministry of Defence, 5



**Figure 6:** Current Health Expenditure<sup>30</sup> by sources of financing, 2020

Source: Malaysia National Health Accounts (2021)

This parallel and dichotomous healthcare system has contributed to a highly imbalanced distribution of services, infrastructure, equipment, manpower and other resources across the two sectors, resulting in severely overstretched public healthcare facilities and workers compared to those in the private sector as vividly demonstrated during the peaks of the COVID-19 pandemic. As an example, public sector clinics comprise 28% of total primary healthcare facilities but handle almost 64% of outpatient visits (Figure 7).



**Figure 7:** Percentage of primary healthcare facilities and outpatient visits between the public and private sectors, 2020

Source: Health Facts (2021), National Health and Morbidity Survey (2019)

<sup>30</sup> Current health expenditure comprises mainly operational expenditures on health and does not include developmental expenditure

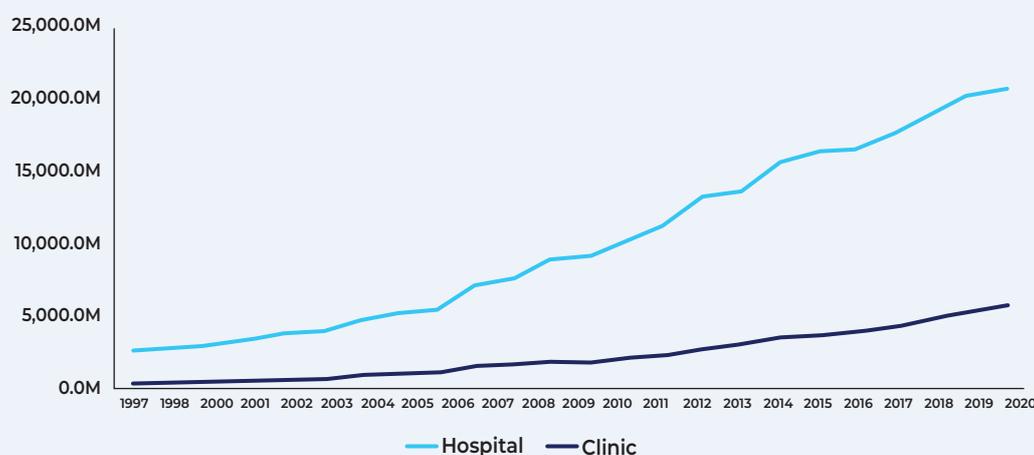
The imbalance is also geographic; public healthcare facilities are distributed across the country, including in rural and remote areas, whereas private healthcare facilities tend to be concentrated in urban areas. As a result of this maldistribution of supply, there are much greater pressures on public sector healthcare resources to cover the needs of the whole population.

The dichotomous healthcare system, together with relative under-investment in health more broadly, has also contributed to a high level of out-of-pocket payments (OOP). Though a proportion of OOP comprises higher-income patients seeking private sector healthcare services, as the public healthcare sector becomes more stretched, more lower-to-middle income patients will seek shorter waiting times and treatment availability in the private sector even at the risk of severe financial hardship<sup>31</sup>.

OOP is inefficient and inequitable as it increases financial risk for households, reduces risk pooling and encourages avoidance of care. OOP health spending is the second largest component of current health expenditure (CHE) today, equivalent to 34.2% of CHE in Malaysia. In comparison, average OOP health spending in other upper-middle income countries such as Thailand and Turkiye stand at 8.7% and 16.9% respectively<sup>32</sup>.

### (b) Imbalance in expenditure between hospital care and clinic care

Malaysia spends a relatively high proportion of its public health resources on hospital care compared to clinic care. Over the period of 1997 to 2020, public expenditure on hospital care exhibited steeper increments compared to public expenditure on clinic care (Figure 8).



**Figure 8:** Public expenditure on hospital care vs. clinic care, 1997-2020

Source: Malaysian National Health Accounts (2020)

The imbalance in expenditure is partly driven by increasing demand for extensive diagnostics and

31 From 2015 to 2019, there was a 5.5% increase in the number of visits per capita to private outpatient healthcare facilities by the lowest income quintile group. 'National Health and Morbidity Survey (NHMS) 2019: Vol. II: Healthcare Demand' and 'National Health and Morbidity Survey (NHMS) 2015: Vol. III: Healthcare Demand.'

32 36 World Bank Data (2022). Out-of-pocket expenditure (% of current health expenditure) - Upper middle income countries. Available at <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS>. Access on 27/08/2022

treatment, particularly for the increasing burden of NCDs and complex care. In addition, costs of diagnosis and treatment have risen over time with the development of new methods and technologies that either require additional capital expenditure or skilled manpower or both.



The imbalance in expenditure between hospital care and clinic care is also driven by insufficient reorganisation to step down relevant services from hospitals to the community level. For example, a significant proportion of conditions such as bronchial asthma, bronchopneumonia and gastroenteritis that could be managed by primary healthcare providers or in ambulatory care settings are currently delivered by hospital care services, which is inefficient and costlier<sup>33</sup>. Moreover, hospital admissions for management of long-term care such as complications of diabetes are very high in Malaysia compared to other countries<sup>34</sup>.

Finally, the increasing trend in hospital care expenditure relative to clinic care is also a reflection of insufficient prioritisation of promotive and preventive approaches to health. An over-emphasis on treatment and curative care as well as over-provision of services in hospital settings will have an increasingly serious cost impact, particularly in the wake of rising NCDs and an ageing population.

### **(c) Imbalance between funding versus demands on the health system**

Malaysia is under-investing in health. In terms of current health expenditure (CHE<sup>35</sup>), Malaysia as an upper-middle income country (UMIC) spent only 4.1% of GDP on health in both the public and private sectors compared to the UMIC average of 7.4% of GDP and the high-income countries' (HIC) average of 8.8% of GDP. Malaysia's public sector share of current health expenditure is only 2.2% of GDP, similarly low compared to the UMIC average of 4.4% of GDP and the HIC average of 6.4% of GDP<sup>36</sup> (Figure 9).

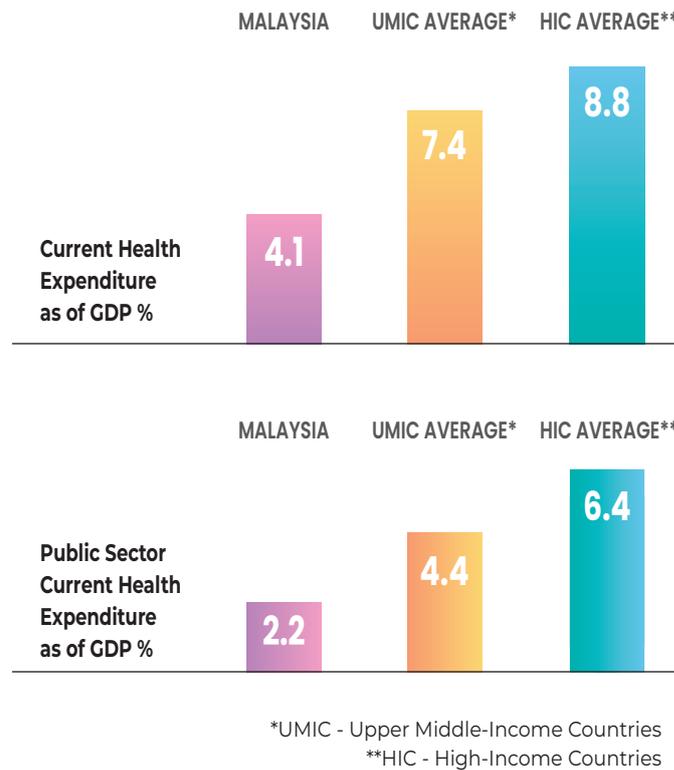
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33 Ibid. 6

34 Ibid. 6

35 Current Health Expenditure (CHE) measures spending by both public and private sources on medical services and goods, public health and prevention programmes and administration, but excludes spending on capital formation/investments (development expenditure).

36 40 Global Health Expenditure database. Available at <https://apps.who.int/nha/database>. Access on 22/09/2022.



**Figure 9:** Current Health Expenditure as % of GDP, Malaysia vs. Upper Middle-Income Countries (UMIC) & High-Income Countries (HIC), 2019  
Source: Global Health Expenditure Database, WHO (2021)



The comparatively low level of healthcare investment, both overall and in the public sector, is being increasingly stretched by changing needs and expectations. Rising burden of disease, an ageing society, changes in technology, increasing demand for pharmaceuticals and consumables, are amongst many factors driving up the demand for greater health investments and expenditure.

Apart from gaps in service delivery, the under-investment has also affected the capacity to close gaps in infrastructure, particularly in IT and digitalisation. Health technology devices and big data analytics are useful enablers in improving service delivery, patient outcomes and evidence-based policy-making. However, the basics need to be in place, for example the electronic medical records (EMR) have yet to be fully rolled out, and there are few linkages between health databases and data registries between healthcare facilities and institutions across both the public and private sectors. Majority of the public sector hospitals and clinics are lagging in major updates to ICT equipment, software and systems including to the Health Information System (HIS), Tele Primary Care (TPC) and Oral Health Care Information System (OHCIS). Public health functions similarly have to catch up to advancements in analytics particularly in disease surveillance systems.

Under-investment in health has affected the capacity of the health workforce to meet current needs, particularly in addressing staff shortages, development of new job scopes, skills development, and staff retention in the public sector. Under-investment has also affected the capacity to undertake the full spectrum of research, from epidemiological research, drug development, clinical trials, to behavioural change research and implementation science.

Sufficient investments are also needed to reduce urban-rural inequalities and inter-regional gaps in access and health outcomes. A sufficient range of healthcare services needs to be effectively and innovatively provided in areas outside of major towns, which mainly depend on public healthcare resources. Many existing facilities and equipment in rural and remote areas are also in great need of repair or replacement.

#### **(d) Limitations in current structures related to resource management, governance, and stewardship**

Today, the Ministry of Health (MOH) shoulders the role of regulator, policymaker, payer as well as healthcare provider<sup>37</sup> which encompasses promotive, preventive, curative and rehabilitative care. This concentration of role and function was appropriate for a small health system and economy that was Malaysia's in the early decades of post-Independence, but it is inadequate for the health system of an upper-middle income economy and a growing population with a multitude of health needs.

The combination of roles and structures have contributed to insufficient check-and-balance between the regulatory and quality assurance function on one hand, and the provision of healthcare services on the other. A clearer separation between the two roles is needed to introduce appropriate competition and innovation in healthcare provision and to ensure more consistent monitoring and evaluation of all health facilities, including public health facilities.

A clearer separation is also needed in order to strengthen the quality and depth of MOH's regulatory and policymaking roles. One example is the regulation of private health insurance which today is under the purview of Bank Negara Malaysia (BNM). Issues such as insufficient service coverage as well as premiums and claims escalation require MOH to play a more prominent role in the governance and stewardship of private health insurance alongside BNM. Other areas calling for clarity and strengthening of policy



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<sup>37</sup> Public healthcare and health-related services are also provided by the Ministry of Education, the Ministry of Defence, the Ministry of Housing and Local Government, the Ministry of Federal Territories and state governments.



making roles include the intersection between healthcare and social care for older people, for people with disabilities (PWD) and for vulnerable groups; the regulation of healthcare services conducted online such as teleconsultations and internet pharmacies; the regulation of healthcare misinformation and many others.

Finally, clearer separation of roles and functions within MOH is needed to facilitate more operational autonomy in public health facilities. Apart from delivering better performance through greater budgetary and management independence, facilitating more autonomy may help to circumvent current limitations on hiring and promoting public sector health staff as well as enabling more staff mobility between the public and the private sectors.

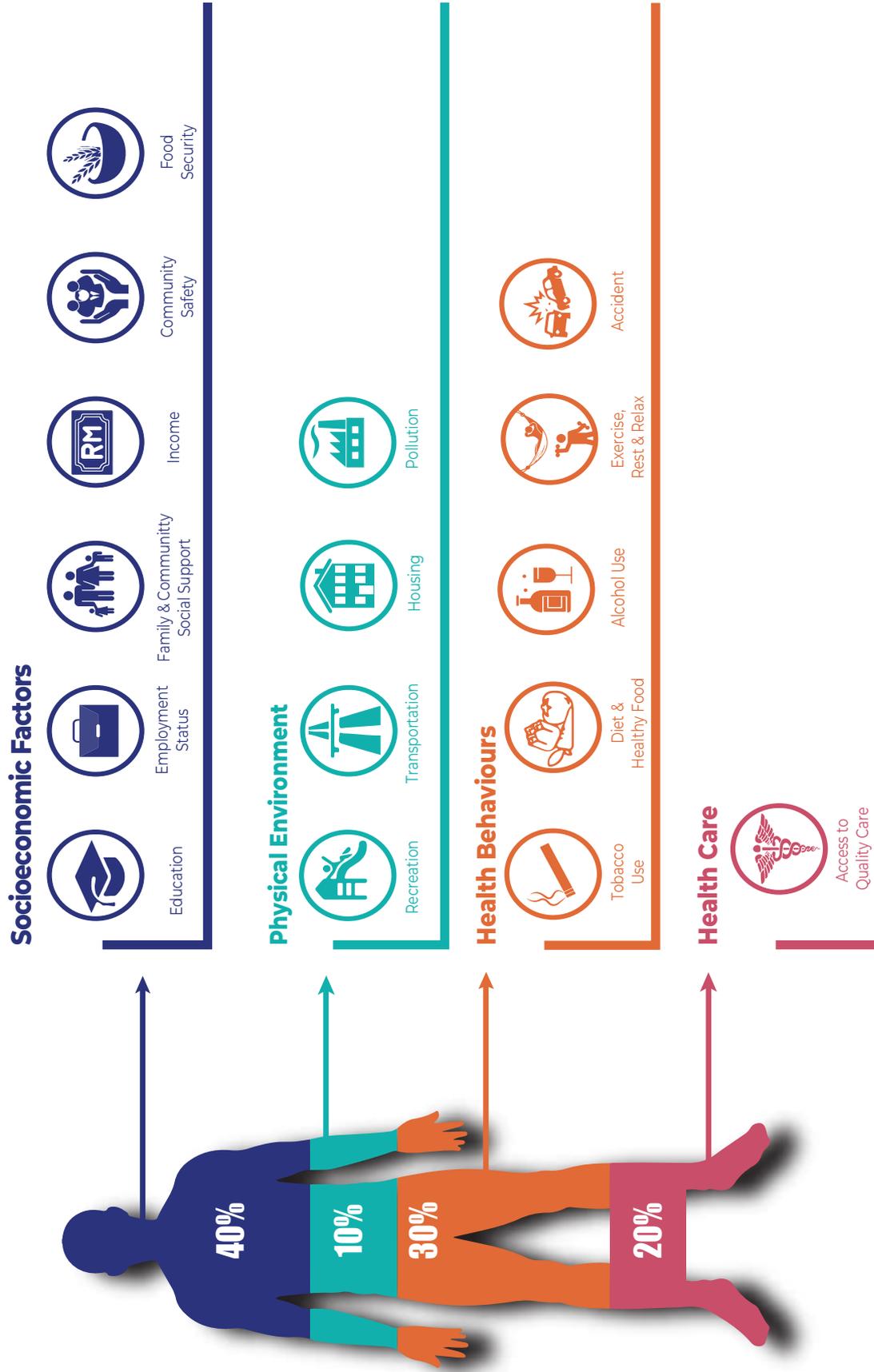
#### **(e) Complex operating environment vs. demands for a coordinated multi-system, multi-sectoral approach**

As outlined above, ill health and disease are partially driven by social and environmental factors such as rapid urbanisation, income, lifestyle, quality of the surrounding environment and many others. Correspondingly, there has been a growing appreciation that achieving health outcomes is not the responsibility of the MOH alone but is the responsibility of all relevant ministries and stakeholders in a Health in All Policies approach<sup>38</sup>.

This approach needs to be deepened such that inter-agency coordination is further improved and that ownership of health outcomes is truly shared. The whole-of-government approach also needs to be expanded and reframed towards a whole-of-society approach that brings in civil society organisations, the private sector and individuals in a more concerted manner compared to the dispersed short-term local projects occurring today. Such multi-sectoral collaborations were enhanced during the height of the COVID-19 pandemic but need to be made more systematic, especially if the paradigm of health is to evolve from focusing on curative care towards emphasising preventive care and the maintenance of health and well-being.

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38 World Health Organization (WHO). (2014). What you need to know about Health in all policies.



**Figure 10:** Social Determinants of Health  
 Source: Going beyond clinical walls: solving complex (2014). Institute for Clinical Systems Improvement and the Robert Wood Johnson Foundation.

The health of a person is highly determined by factors surrounding them. The risk of succumbing to a communicable disease, for example, is greater in high-density living environments. The risk of developing a non-communicable disease such as diabetes or heart conditions increases with continuous exposure to toxins like unhealthy food, smoking, stress, and pollution which in turn are influenced by income, living environment, lifestyle, and others. These factors are called social determinants of health (SDH).

Estimates show that access to healthcare may only contribute 20% to a person's health while SDHs, which encompass socioeconomic factors, physical surroundings, and health behaviours, could account for 80% of the factors that determine a person's health (Fig. 10).





# Chapter 2

## Purpose, Scope and Aspirations for Malaysia's Health System

### 2.1 Purpose and Scope of the Health White Paper

As outlined in Chapter 1, the coming decades will see significant demands on the Malaysian health system driven by the increased burden of both communicable and non-communicable diseases, an ageing population and rising healthcare costs, amongst others. At the same time, digitalisation and technological advancements create opportunities for more timely and accurate diagnosis, better treatment, monitoring and care as well as better preventive measures. Robust reforms that address the systemic issues of the health system would enable Malaysia to respond more effectively to future challenges and opportunities, to support the population's health as a key component of social protection.

#### The HWP seeks to:

1

Make the case for reform towards a more equitable, sustainable, and resilient health system that serves the needs of the people at all stages of life

2

Propose reforms covering key areas such as service delivery, promotive and preventive approaches, financing, human resources for health and system governance over a 15-year period.



In line with this, the purpose of the HWP is to propose the major changes needed to ensure that Malaysia's health system can anticipate and fulfil the nation's evolving health needs while still maintaining affordability and financial protection, particularly for lower income and vulnerable groups. These vital changes will need to be implemented in phases and thus will require long-term commitment and support from all major stakeholder groups in the country. Consequently, the HWP is to be tabled to the Malaysian Parliament in order to secure firm democratic backing for the significant work that lies ahead.

The HWP was formulated by the Ministry of Health in consultation with other ministries and agencies as well as many stakeholder groups across the private sector and civil society. Findings, recommendations, and plans from previous health system studies, MOH policy papers and evidence from various international benchmarks and academic literature were also considered and incorporated.

To ensure that the HWP covers the most pressing and longstanding needs of the country's health system however, the HWP's proposals are focused on system-wide reforms to address the systemic and structural gaps outlined in the preceding section.

Further levels of detail in terms of policy design and implementation will be taken up in subsequent implementation stages.

## **2.2 Aspirations for Malaysia's Health System and Reform Pillars**

Based on the needs assessment of several systems studies as well as engagement sessions with numerous stakeholder groups, the HWP proposes the following aspirations for the nation's health system:

## **A healthy nation**

The HWP envisions a paradigm shift from 'sick care' towards a system that supports the population to stay healthy or get back to health. This involves reforming the health system towards facilitating healthy living for all ages including vulnerable groups; increasing evidence-based preventive practices such as cessation programmes, regular screenings, and self-monitoring; and strengthening the capacity of healthcare services in promotive and preventive care. A 'whole of nation' approach will be forged with greater collaboration and partnership between government entities, non-profit organisations, the private sector, community groups and individuals to address the range of factors that drive health outcomes. A change in mindset and behaviour is also envisioned where health becomes a priority and a shared responsibility across all stakeholder groups, "all for health, health for all" with high levels of personal medical literacy, personal health ownership and vibrant multi-sectoral engagement in the development of health-related policies and health-promoting environments.

## **An equitable and person-centred health system**

The HWP envisions a health system in which the population has reasonably easy access to good quality and affordable health services. This would require ensuring that both the public and private healthcare sectors work harmoniously and cost-effectively, together providing services that address the varied health challenges in the community with coordination, expertise and empathy. Primary healthcare would need to be enhanced to become the first line of defence, with primary healthcare providers being the main point of contact for an individual's health needs throughout the person's life course. Service delivery would need to be transformed to be closer to the community and designed to be more in keeping with the individual's convenience and limitations, including geographical constraints. Apart from improvements in service effectiveness, the health system will need to be adequately funded to ensure that health services are kept affordable and that vulnerable populations have financial protection against catastrophic medical costs.

## **A resilient health system**

The HWP envisions a health system able to anticipate, adapt and respond to demands from known health challenges such as NCDs as well as rapid health emergencies such as infectious disease outbreaks, pandemics, and climate events. This involves ensuring that public health functions are supported and equipped for surveillance, response preparedness and foresight of potential scenarios, informed by changes in planetary health and people flows. A resilient health system also requires resilient health system also requires to evolving health needs and demands, which includes having sustainable and dependable sources of funding together with a robust health procurement system that is cost-effective, value-based and trusted by the people.

### **An open and innovative health ecosystem**

The HWP envisions a health ecosystem that continuously learns, adapts, and improves itself to take on new and effective ways of achieving the aspirations of a healthy nation. This requires a firm commitment towards modernisation and digitalisation, not only in terms of electronic medical records or the use of devices for self-monitoring, but also the application of new technologies and methods of data analysis for more evidence-based care and policies. Achieving an open and innovative health ecosystem would also require more investments in health-related research across diverse areas, from development of scalable and affordable solutions in screening, drugs, and treatments, to interventions that change health-related behaviours. There will be more space and resources for trialling and scaling up new ways of working, learning from best practices on the ground be it in service delivery, public health outreach or other measures to affect social and non-social determinants of health.

### **A health system prized and valued by the people**

The HWP envisions a health and healthcare system that is identifiable as a set of interlinked entities and a public good to the people. The equitability, accessibility and resilience of the health system is something deeply valued by the people and there is active interest by all parties in improving the system continually.

The HWP proposes to achieve the above aspirations statement with the following reform pillars and strategies (Table 1):



Table 1: National Health System Reform Framework

ASPIRATIONS

- A healthy nation
- An equitable and person-centred health system
- A resilient health system
- An open and innovative health ecosystem
- A health system prized and valued by the people

### Health Reform Pillars & Strategies:

<div style="background-color: #002060; color: white; padding: 10px; border-radius: 15px 15px 0 0; display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center; font-weight: bold; font-size: 1.5em;">Pillar 1</div> <div style="font-weight: bold; font-size: 1.1em;">Transforming Health Service Delivery</div> </div> <ul style="list-style-type: none"> <li>• Prioritising primary healthcare</li> <li>• Optimising hospital care services</li> <li>• Increasing effective public-private partnerships</li> <li>• Harnessing digital technologies</li> <li>• Ensuring equity in healthcare delivery</li> </ul>	<div style="background-color: #00A09A; color: white; padding: 10px; border-radius: 15px 15px 0 0; display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center; font-weight: bold; font-size: 1.5em;">Pillar 2</div> <div style="font-weight: bold; font-size: 1.1em;">Advancing Health Promotion and Disease Prevention</div> </div> <ul style="list-style-type: none"> <li>• Strengthening public health functions</li> <li>• Improving inter-sectoral coordination and collaboration for health</li> <li>• Incentivising pro-health practices and behaviours</li> </ul>
<div style="background-color: #E67E22; color: white; padding: 10px; border-radius: 15px 15px 0 0; display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center; font-weight: bold; font-size: 1.5em;">Pillar 3</div> <div style="font-weight: bold; font-size: 1.1em;">Ensuring Sustainable and Equitable Health Financing</div> </div> <ul style="list-style-type: none"> <li>• Increasing investments for health</li> <li>• Ensuring population receive comprehensive services that are affordable</li> <li>• Ensuring effective and efficient healthcare spending</li> </ul>	<div style="background-color: #C0392B; color: white; padding: 10px; border-radius: 15px 15px 0 0; display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center; font-weight: bold; font-size: 1.5em;">Pillar 4</div> <div style="font-weight: bold; font-size: 1.1em;">Strengthening the Health System's Foundations and Governance</div> </div> <ul style="list-style-type: none"> <li>• Restructuring MOH's role</li> <li>• Strengthening policies, legislation and regulations</li> <li>• Fortifying the health workforce</li> <li>• Stimulating research, innovation, and evidence-based approaches</li> </ul>



# Chapter 3

## Health Reform Pillars and Strategies

### 3.1 Pillar 1: Transforming Health Service Delivery

This reform pillar comprises major systemic and structural improvements related to the way health services are organised and delivered. The key principles of pillar 1 include: more effective distribution of services across primary, secondary, and tertiary care; more effective utilisation of capacities and capabilities across the public and private sectors; significant improvements in operational effectiveness; and continued improvements in service accessibility.

#### 5 reform strategies

Prioritising primary health care



Optimising hospital care services



Increasing effective public-private partnerships



Harnessing digital technologies



Ensuring equity in healthcare delivery



### 3.1.1 Prioritising primary health care<sup>39</sup>

Improving the nation's health outcomes over the long run requires transitioning to new service models that deliver more care closer to the community. Towards that end, the role of primary health care (PHC) will be transformed to become the first line of defence in monitoring and managing the population's health status. Accordingly, investments and resource allocations in primary health care will be increased, from funding to human resources, facilities, and equipment to standardise services as required for the national health system.

In delivering more comprehensive person-centred care closer to the community, PHC providers will be the first point of contact where the population will receive a wide range of services, including promotive, preventive, curative, rehabilitative and palliative care<sup>40</sup>. Every person will gradually be enrolled to an accredited PHC provider of choice close to their homes or workplace.

The provision of PHC services will be led by the establishment of PHC teams consisting of multi-disciplinary professionals. The composition of PHC team will evolve<sup>41</sup> over time as the public health system's benefit package becomes progressively more comprehensive.

The PHC team will be responsible for monitoring the health status of a designated population in the clinics or team's operational area. With this approach, a long-term patient-doctor relationship can be cultivated which will enhance the quality and continuity of care as well as patient compliance towards the treatment and management provided. There will also be greater coordinated care across different sectors and levels of care. Referrals for specialist care or hospitalisation will be coordinated by the PHC team, enabled by electronic medical records (EMR) and clear feedback procedures across care pathways and facilities.

To improve access, the transformation of PHC will begin with public sector providers and gradually encompass the private sector. Access to PHC services will also be increased via



39 Primary health care is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment

40 Whether delivered at the PHC facility, at the patient's home or online/remotely

41 The basic PHC team - will consist of doctors, paramedics such as assistant medical officers or nurses and pharmacists. Other professionals will also be included in the PHC team progressively, as needed. The PHC team concept will be applicable to mobile health teams working in remote areas, depending on the needs of the area.

operational enhancements including improved appointment scheduling, expanded hours, use of tele-health, amongst others. Training and capacity-building of PHC providers will be facilitated to support providers in realising the PHC team concept and associated standards.

Over time, improvements in the health information system infrastructure and analytics will enable PHC providers and PHC teams to incorporate continuing advances in healthcare technologies. The introduction of more management, operational and financial autonomy will also be progressively implemented for public sector primary healthcare providers, where feasible.

This far-reaching transformation in care model is aimed at achieving better health outcomes more sustainably over the long run. Successful transformation of PHC will aid in gradually reducing demand for care in secondary and tertiary facilities as well as reducing the prevalence of illness and disease through earlier diagnosis, interventions, and better case management throughout a person's life. This reform also seeks to achieve greater coordination across different levels of care and across providers from different sectors.

A pilot program to implement the enhanced primary health care concept has been undertaken from 2017 but a long-term transformation needs to be supported by other inter-linked initiatives. The HWP proposes to supplement and scale these efforts by:

- 01** Reviewing and strengthening the enhanced PHC masterplan, including incorporating key learnings from the pilot program, integrating more cross-sectoral linkages, relooking requirements for training & upskilling and reviewing budgetary allocations.
- 02** Strengthening MOH's regulatory role including reviewing and updating accreditation and performance standards for PHC providers across the public, private and non-profit sectors.
- 03** Developing a comprehensive framework for public-private partnership in PHC service provision including mechanisms to ensure value-based services<sup>42</sup> and balanced coverage across geographies.

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42 Value-based services is a delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are incentivised to help patients improve their health status, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

**04**

Implementation of secure EMR and LHR with interoperability between healthcare providers.

**05**

Developing and implementing the human resource requirements for the transformation of PHC, including defining new positions, training, and credentialing.

**06**

Planning and progressive implementation of the provider autonomy initiative.

### 3.1.2 Optimising hospital care services

In tandem with the move to transform primary health care (PHC), hospital care services within the public sector will be right-sized to improve efficiency and reoriented to focus on acute care and complex inpatient care management. The performance and quality of hospital services will also be improved through a range of key enabling initiatives.

Ambulatory care sensitive conditions such as lung and respiratory tract infection, diarrhoea and asthma that are better addressed in PHC and community settings will be progressively shifted out of hospital settings. Long term care such as for fragile older persons or for management of NCD-related complications will also be increasingly managed outside hospital settings in collaboration with social, rehabilitative, or palliative care providers, including community organisations. Similarly, transitional care management such as post-operative care will be increasingly placed at the community level to reduce re-hospitalisation after discharge.

**Ambulatory care sensitive conditions such as lung and respiratory tract infection, diarrhoea and asthma are better addressed in PHC and community**

The performance and efficiency of public sector hospitals will be enhanced via a hospital autonomy initiative<sup>43</sup> where through progressive decentralisation, public sector hospitals will have greater independence within a defined management framework. The autonomous arrangement will be in line with the efforts of the cluster concept where public sector hospitals in the same area will be organised to further increase efficiency in administration and procurement management, human

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<sup>43</sup> Report by the World Bank (2012) on the implementation of Vietnam's hospital autonomy initiative demonstrated a increased hospital capital investment, expansion in the range of healthcare services provided, increase in hospital utilisation, growth in public hospital medical staff income, growth in total hospital revenues, overall reduced costs and more effective use of human resources.

resources and the sharing of other resources for health through collaboration between facilities in the cluster. The provider cluster concept<sup>44</sup> will also serve as a platform for more integrated clinical service delivery across facilities. The hospital cluster concept will initially encompass district hospitals and specialist hospitals in KKM by stages, and progressively include facilities under the Ministry of Higher Education and the Ministry of Defence.

Apart from that, increasing hospital autonomy will require upfront investment to build managerial capacity within the public sector hospitals. To address remaining gaps in human resources at hospitals, overall human resource mapping for the healthcare sector will be revised and updated to outline current and future needs for specialists and other hospital care health workers. As was proposed for primary health care, the efficiency and effectiveness of hospitals will be improved with the roll-out of electronic medical records (EMR) and electronic lifetime health records (ELHR).



Public-private partnerships will also extend to the hospital care level. Procurement of hospital care services from the private sector will be progressively and strategically implemented. In addition to increasing people's access to health services, this partnership also optimises health resources within the public hospital facilities and between public and private hospital facilities. Public-private partnerships will also be enhanced for pre-hospital care and ambulance services, towards making these services more responsive.

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44 Study by Ng RJ (2020) on current Malaysian cluster hospital initiatives showed patients have increased access to specialist services, better quality of care with shorter waiting time, reduced travelling time, reduced out-of-pocket expenditure and reduced productivity loss.

Reform efforts towards optimising hospital services are currently in exploratory and planning stages. To further these efforts, the HWP proposes to embark on the following multi-year initiatives:

**01** Progressive shifting out of ambulatory care sensitive conditions with domiciliary care services post-discharge.

**02** Strengthening and expansion of provider cluster initiative.

**03** Design, planning and progressive implementation of the hospital autonomy initiative.

**04** Developing a comprehensive framework for public-private partnership in secondary and tertiary service provision including mechanisms to ensure value-based services<sup>45</sup> with balanced coverage of specialists across facilities and geographies.

**05** Implementation of secure and shareable LHR and EMR, with interoperability between healthcare providers.

**06** Developing and implementing the human resource requirements for the optimisation of hospital care, including defining new positions and training.

### 3.1.3 Increasing effective public-private partnerships

Improving access to health care services, including at the community level, involves addressing the imbalance in workload and resource utilisation across the public, private and not-for-profit sectors. This can be achieved through more effective intersectoral partnership in delivering affordable care at the primary, secondary and tertiary care levels. Public healthcare facilities will be less crowded and waiting times will be reduced particularly for high-demand procedures.

To enable this systemic transformation, a robust framework for procurement of health care services and medications will be established which includes the development of value-based payment models, formalisation of a strategic purchasing function, governance, and enforcement structures to ensure service quality, and others.

At the provider level, public-private partnership in service delivery will be further enabled by the implementation of shareable medical information and records with clear referral and follow-up guidelines. This will allow inter-sectoral referrals and feedback processes to operate efficiently.

Effective public-private partnership will help to balance resource utilisation across the public, private

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<sup>45</sup> Ibid 42

and non-profit sectors. More people will have greater access to a range of healthcare services including services in the community. Effective collaboration between the sectors also will ensure the delivery of health care services at reasonable cost across every level of health care.

Public-private partnerships in the delivery of healthcare services are still at early stages, involving mainly COVID-19 vaccination and PeKa B40 screening. The HWP proposes to deepen these initiatives with the following multi-year initiatives:



01

Developing a comprehensive framework for procurement and public-private partnership in healthcare service provision including establishment of value-based payment models, demand-supply mapping, strengthening of the strategic purchaser function and other key components.

02

Reviewing and updating accreditation and performance standards for healthcare providers across the public, private and non-profit sectors.

03

Implementation of secure shareable EMR and LHR, with interoperability between healthcare providers.

### 3.1.4 Harnessing digital technologies

Electronic medical records (EMR) and electronic lifetime health records (ELHR) will be rolled out in stages, containing the individual's personal health status, medical history, and other relevant information such as social determinants of health. Shareable and interoperable EMR and ELHR will be implemented to enable seamless and secure exchange of information between providers.

Data ownership will reside with the individual who grants providers and the government access to their personal information, thereby ensuring personal health data privacy and confidentiality. The EMR and ELHR will not only be used as a historical repository but also to enable intelligent development of personalised treatment plans in future.

Digitalisation will also increase efficiency and innovation of service delivery processes such as telemedicine especially for hard to reach populations, appointment scheduling, lab information systems and others to facilitate and improve the responsiveness of the health system. Stable patients can save time and money by opting for virtual consultation without physically attending the clinic. In relation to that, IT infrastructure, equipment and software will be improved in stages so that the digitalisation of the health system can be widely implemented.

The analytics of nationwide health data will also support evidence-based medicine, enabling healthcare providers to deliver better precision care through data-driven best practices and algorithms in risk profiling, disease prevention, diagnosis, disease classification, clinical investigation and treatment.

Key digitalisation initiatives are currently in planning and pilot stages. The HWP proposes to achieve full realisation of initiatives as follows:

Implementing the MOH ICT Masterplan including phased roll-out of EMR and ELHR; development of a Health Information Exchange (HIE) as a secure integration and sharing platform; and strengthening human resource capacity in information systems and data analytics.

Implementing new guidelines, SOPs, and training to integrate digitalisation in processes within and across facilities.

Strategic review and implementation of initiatives to strengthen the policy framework, processes and regulatory capacity governing health data privacy and protection.



### 3.1.5 Ensuring equity in healthcare delivery

Ensuring equity in access to healthcare for diverse groups faced with a range of needs during different life phases remains a challenge, particularly within the realities of a resource-limited health system. New approaches to resource allocation, planning and monitoring need to be put in place in order to ensure that vulnerable groups receive sufficient healthcare and systemic inequalities in health are addressed.

Current policies and approaches will be reviewed and updated to address health inequities or gaps to facilitate the implementation of more integrated efforts in the future, especially efforts involving coordination among various stakeholders. With this, health inequities between regions and community groups will be reduced and better monitored. An important group requiring cohesive responses to their emerging health needs is the growing population of older persons. In addition to strengthening coordination platforms with relevant ministries and agencies, particularly on the intersection of social care with healthcare, a strategic review of the health system's preparedness to address future needs of the ageing population will be undertaken. The demand forecast for services, facilities, human resources, technology, and funding will be included in the scope, as well as options for the expansion of benefit package and contribution schemes to encompass long-term care .

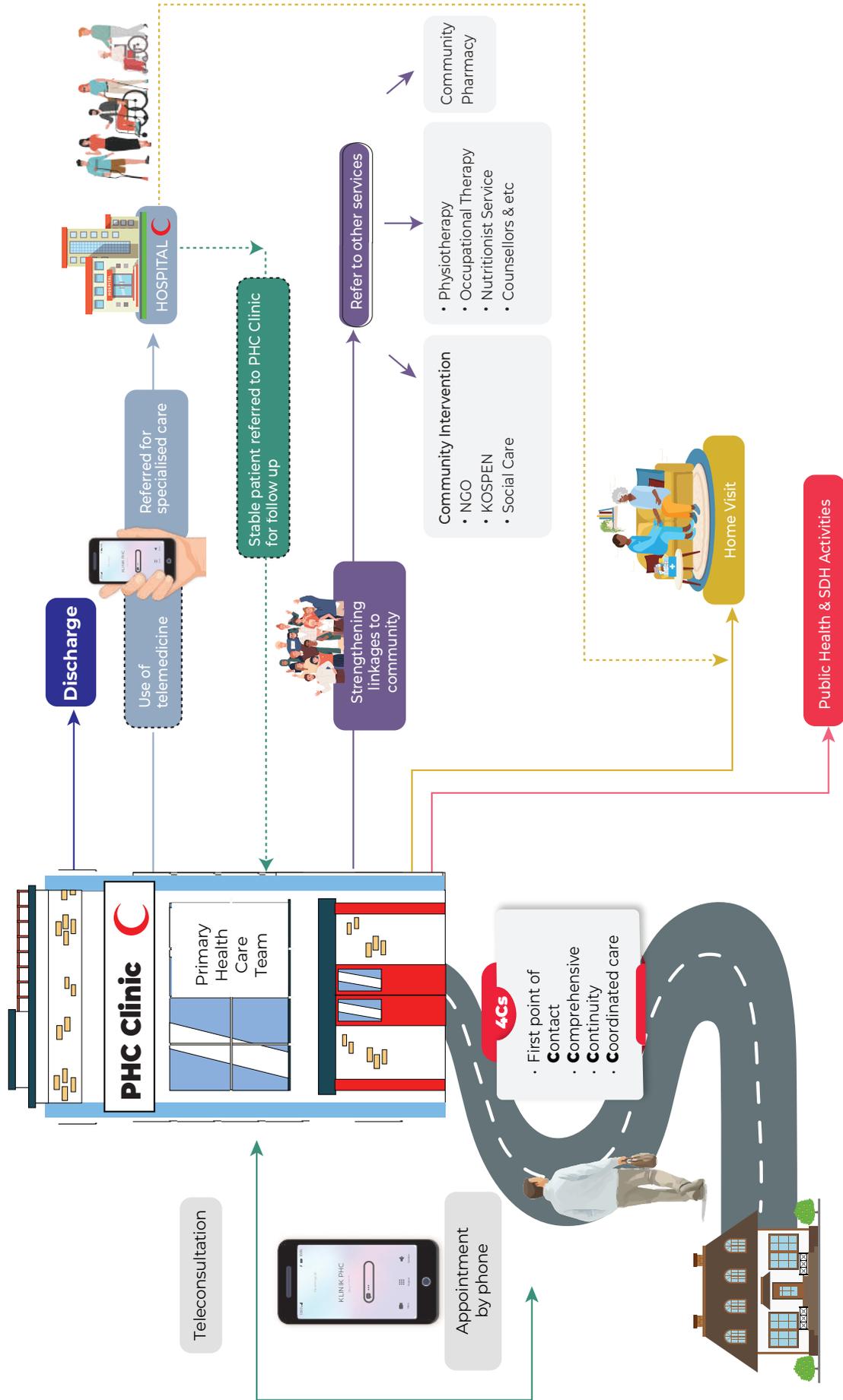
The geographic and socioeconomic characteristics of Sabah and Sarawak present specific challenges in delivering equity in access and coverage to the populations of these states. In close partnership with state representatives, a strategic review to improve decision-making processes involving resource allocation, planning, service modalities, technology, and human resources for the health ecosystems of Sabah and Sarawak respectively will be undertaken.

The challenge of access for non-citizens which include the undocumented, the stateless, migrant workers, refugees, and asylum seekers is a concern requiring attention. Existing cross-cutting policies and guidelines that impact accessibility, need to be reviewed in order to improve access to healthcare for all these groups.

A similar policy and operational review will be undertaken in order to strengthen access and quality of care for vulnerable groups such as *Orang Asal*, persons with disabilities, persons living with or at risk of HIV, victims of domestic violence and abuse, prisoners, the homeless and other groups in need of support or protection. Current platforms and pathways for coordination with relevant ministries and community groups will also be strengthened towards addressing the health needs of vulnerable and marginalised groups .

Providing improved access to healthcare is an integral and on-going part of the MOH's and the government's policy-making and programmatic efforts. The HWP proposes to further address systemic or structural challenges in improving equitability of access as follows:

- 01** Undertaking a strategic review of the healthcare system's preparedness to address future needs of the ageing population.
- 02** Strengthening inter-agency and inter-sectoral coordination on policies and programs impacting the older persons population, including enabling healthy ageing.
- 03** Undertaking a strategic review to improve resource allocation, planning, service modalities, technology, and human resources for the health ecosystems according to needs.
- 04** Undertaking a policy and operational review of current approaches in adequacy of coverage and service delivery for vulnerable and marginalised populations.



**Exhibit 1: Transforming the patient journey in the Malaysian Health System**  
**An overview of the envisioned future patient experience resulting from the HWP's proposed service delivery reforms**

## 3.2 Pillar 2: Advancing Health Promotion and Disease Prevention

This reform pillar comprises major systemic and structural improvements aimed at reorienting the health ecosystem towards fundamentally integrating the promotion of health and the prevention of illness in all policies, guidelines, practices and in daily life. The key principles of this pillar include: improving the effectiveness of public health policies and activities by the MOH; better mechanisms to increase ownership and coordination across all relevant stakeholders in the health ecosystem; and leveraging improvements in technology and behavioural sciences to introduce more effective preventive measures.



### 3.2.1 Strengthening public health functions

Improving the nation's health outcomes in the face of rising incidence of NCDs and uncertain threats from infectious diseases requires a renewed focus on public health. In line with the paradigm shift towards more effective promotive and preventive approaches, the mandate and resourcing of public health in terms of funding, human resources, IT, research and other enabling inputs will be reviewed and enhanced towards strengthening its associated functions and activities<sup>46</sup>.

Sharing of clinical and research data as well as analytics capability, particularly in Geographic Information Systems (GIS) and artificial intelligence (AI), will be enhanced to strengthen disease surveillance, monitoring and community-level risk-profiling. Enhanced data gathering and analytics will also drive more evidence-based public health preventive interventions such as public vaccination programs, community screening programs and nutrition programs, amongst others. In tandem with the increased application of data and analytics, the capacity for foresight in public health will be strengthened to include anticipation of accumulating health impact from climate change and planetary health.

**Paradigm shift towards more effective promotive and preventive approaches**

<sup>46</sup> Ministry of Health (2022). An overview of Disaster Life Support in Disaster Management.



Improvement in data gathering and analytics will also be applied towards strengthening the country's health emergency preparedness and response efforts. The COVID-19 pandemic had clearly revealed vulnerabilities in these areas, particularly relating to cross-agency and cross-boundary coordination.

International and intra-regional collaborative platforms will be improved, including regional reference lab networks as well as rapid response communications networks. To further ensure a high level of preparedness and response to public health emergencies, a National Centre of Disease Control will be established to be the cornerstone of preparedness and response against infectious diseases, including coordinating the distribution of the health workforce in times of crisis. The COVID-19 pandemic also underlined the importance of ensuring the availability and sufficiency of medical equipment, diagnostics, and vital medication. To that end, new strategies will be developed to address this issue including facilitating the expansion of local production.

The function of public communications and outreach for health will be enhanced by incorporating insights from behavioural science as well as public-private collaborations to increase uptake of preventive health services, adoption of healthy lifestyle choices, control of infectious diseases and to address health misinformation. In addition to working closely with health care providers, public health outreach activities will be supported by community health volunteers<sup>47</sup> in a more structured and incentivised manner to ensure effectiveness and continuity.

Communications and outreach will be further enhanced by a more concerted effort to improve the content and delivery of health education in schools, workplaces, and other key public touchpoints. Public health outreach activities will also be reinforced to close the health disparities between vulnerable groups and the general population.

Public health objectives are delivered more comprehensively when backed by the letter of the law and

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<sup>47</sup> Under community empowerment programs such as KOSPEN, MyChampion and others community-based organisations

enforcement powers. The translation of evidence-based public health practices into policy, legislation and regulations will be increased, where appropriate. The resources and processes for enforcing public health regulations will be fortified. Towards increasing the capacity and mandate of public health in Malaysia, an agency will be established to coordinate and drive forward health promotion and disease prevention at a national level.

Strengthening public health functions will enhance and safeguard the overall well-being of communities and the population. Community-based programs will play a major role in promoting healthy behaviours amongst the population and reducing the prevalence of chronic diseases such as heart disease and diabetes. Outbreaks and spread of communicable diseases will be more effectively curtailed or avoided, including vaccine-preventable diseases. Improved health communication and outreach will also empower the people to combat misinformation. Communities will be more resilient to withstand threats to their health and well-being.

Initiatives to strengthen the range of public health functions are in the conceptual or planning stages. The HWP proposes to follow through as follows:

**01**

Progressive upgrading of public health surveillance, monitoring and intervention programmes through linkages to national health data and analytics initiatives.

**02**

Establishment of a National Centre of Disease Control.

**03**

Strategic review and enhancement of public health communications and outreach functions, supported by stronger linkages to behavioural research unit, providers, corporates, and community volunteers.

**04**

Reviewing of funding, IT, and human resource requirements for public health, including enforcement functions.

**05**

Strengthening research programmes at the National Institutes of Health as well as collaborations with other academic and research institutions to deepen the evidence base for public health interventions.



### 3.2.2 Improving inter-sectoral coordination and collaboration for health

Health is central to the well-being of the population as well as the stability and prosperity of a nation. However, health outcomes are not only determined by access to healthcare services but are also shaped by social, cultural, economic, and environmental factors which lie beyond the purview of the MOH and health workers. Realising health at all levels will require more joint ownership, shared responsibility, and coordination across government and across non-governmental stakeholders.

A serious imminent challenge for the country is to ensure healthy ageing and minimise infirmity amongst a rapidly ageing population. Coordination and interlinkages with the relevant ministries and agencies will be strengthened via a focused inter ministerial taskforce to address the intersections and interdependencies between the health care system and the social care system, including long-term care for the elderly.

To address health outcomes and social determinants of health (SDHs) more broadly, measures to achieve a whole-of-government approach will be improved to effect more cross-ministry ownership and coordination. Existing collaborative platforms, such as cross-agency committees to monitor achievement of the United Nations Sustainable Development Goals (SDGs), will be leveraged to improve monitoring of inter-ministerial actions on SDHs.

To reinforce shared ownership further, shared health key performance indicators (KPIs) and joint budgets for cross-agency projects on health will be implemented. Health impact assessments and health budgeting<sup>48</sup> will be integrated into current outcome-based budgeting processes at both annual and medium-term planning cycles to connect strategies to action.

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48 Health budget is an amount of money used to support the health and wellbeing needs of the people, which is planned and agreed between ministries and agencies. It is not new money, but it may mean spending money differently so that the people can get the care that they need.

Human resources that support health outcomes in all ministries and agencies such as community workers and allied health professionals will be better coordinated to deliver shared health targets. Finally, a cross-ministry Health in All Policies Task Force will be established to coordinate and implement cross-cutting health-related policies and programs, particularly to address health inequalities due to poverty, food insecurity and education.

The whole-of-government approach outlined above needs to be supported by a whole-of-society approach to health, encompassing non-governmental organisations, civil society, academia, businesses, schools, media, advocates, and other actors. Partnership and connections across different stakeholders will be strengthened via the development of a clear and systematic framework for cooperation.

Improving inter-agency and inter-sectoral collaboration will help to address the many complex and interlinked factors influencing health outcomes, many of which lie beyond healthcare. Promotive and preventive health approaches will become more innovative and effective as a result of combining expertise and perspectives, and the population will receive more comprehensive support in leading healthy lives.

Initiatives to improve inter-agency and inter-sectoral coordination in health are continuously undertaken, with room for improvement. The HWP proposes to increase the pace and impact of multi-stakeholder coordination as follows:

- Formalisation of inter-ministerial taskforce on healthy ageing and aged care.
- Development and establishment of cross-agency shared health KPIs, joint-programme budgets and health impact & budgeting frameworks.
- Establishment of a cross-agency Health In All Policies Task Force to monitor shared health KPIs, coordinate human resources and resolve coordination issues on addressing SDHs.
- Development of cooperation framework for inter-sectoral collaboration at the community level.

### 3.2.3 Incentivising pro-health practices and behaviours

Incentives and disincentives play a significant role in shaping health outcomes. In step with the shift towards more effective promotive and preventive approaches, the design and implementation of incentives and disincentives will be increased to stimulate more healthy choices and behaviours.

Conventional tax-based approaches on sugar-sweetened beverages, cigarettes, alcohol, and other unhealthy consumer goods will be continued and refined to discourage excessive consumption of these goods. Legislation limiting the sale or situational consumption<sup>49</sup> of goods known to be harmful will be introduced, if feasible.

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<sup>49</sup> Example of situational consumption include consumption in public areas or by targeted age groups

More importantly, new approaches will be developed towards incentivising healthy behaviours at the individual level. Financial and non-financial incentives will be designed to improve the level of physical activity, nutrition, health screening and personal monitoring of health status, supported by behavioural science evidence as well as the roll-out of LHR and technology adoption initiatives including wearables. Behavioural incentives will be accompanied with targeted subsidies to improve take-up amongst low-income and vulnerable groups.

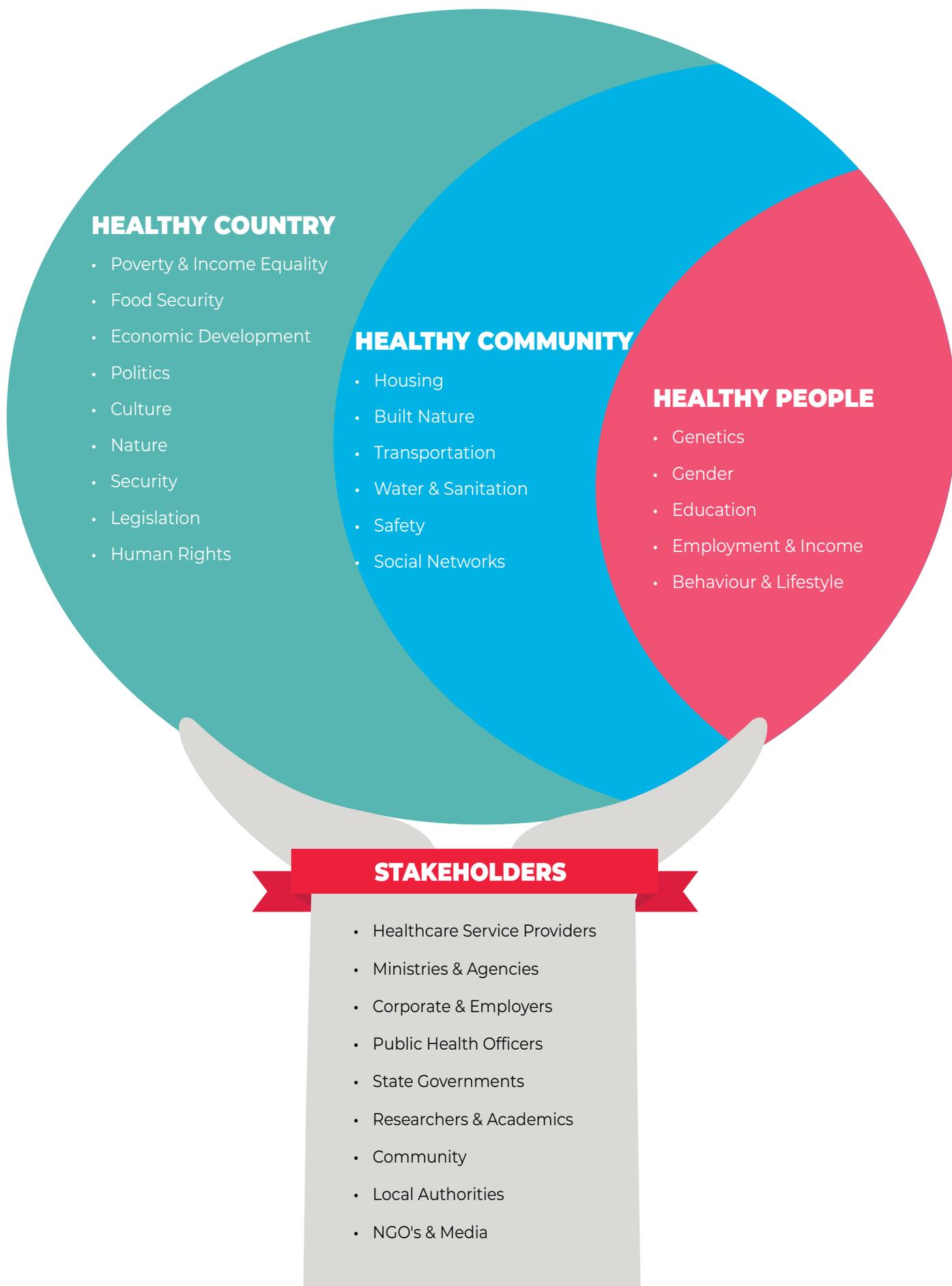
Healthy behaviours at the individual level will also be encouraged through employers and corporations. Food and retail businesses will be incentivised to change their impact on individual nutritional consumption, from improving ingredients or formulations to indicating healthier options. Incentives will also be designed to encourage employers, companies, insurers, agencies, and ministries to implement programmes targeting improvements in staff health outcomes.

Healthcare providers, particularly at the primary healthcare and community level, will also be incentivised to provide effective promotive and preventive services. Value-based payment models will be structured to recognise and reward improvements in patients' health behaviours and health outcomes over time.

Incentivising pro-health practices and behaviours will help to motivate individuals' ownership of health at the practical level, promoting the *practice* of health in addition to raising awareness. Healthcare providers will also become more attuned towards improving the delivery of promotive and preventive care, prioritising preventive health plans as well as the continuous monitoring of patients' health status.

Current initiatives in designing and implementing incentives for health are at planning or conceptual stages. The HWP proposes to reinforce these initiatives as follows:

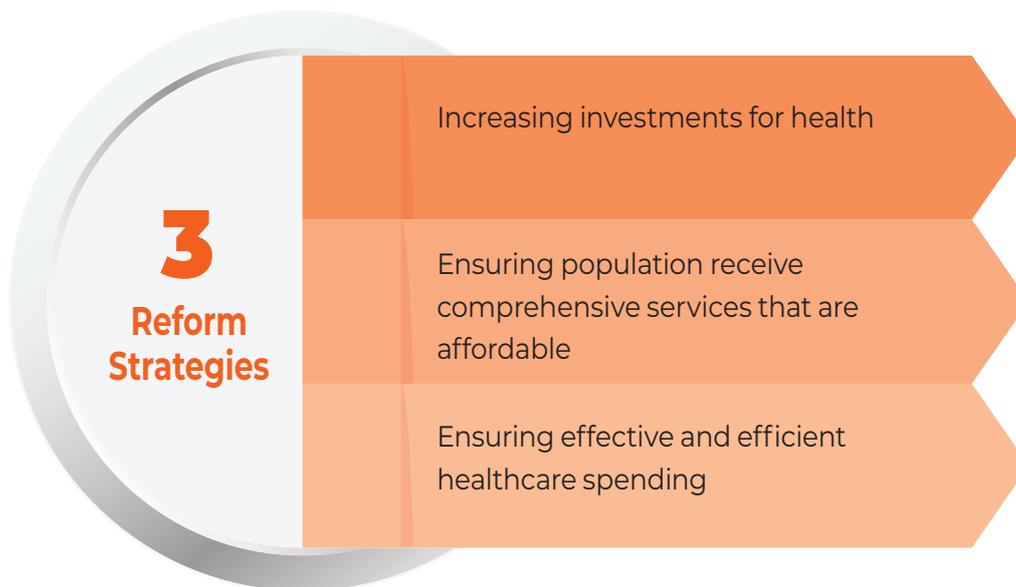




**Exhibit 2:** Social determinants of health at individual, community and country levels with health actors

### 3.3 Pillar 3: Ensuring Sustainable and Equitable Health Financing

This reform pillar comprises major systemic and structural improvements aimed at making health financing more sustainable and value-driven while providing better financial risk protection and lowering out-of-pocket expenditure. The key principles of this pillar include: progressively increasing investments into health, diversifying sources of health funding, pooling of risk, and increasing the effectiveness of health spending.



#### 3.3.1 Increasing investments for health

Malaysia is currently under-investing in health and it does not match the increasing demand of current and future needs. There is a great need to increase investment into the health system in order to realise the much-needed reform while taking into account the Government's position and fiscal capacity.

The Government's role in this aspect is important to attain Universal Health Coverage and protect individuals from financial risk when they fall ill. Publicly managed health funding from various sources including the Government, individuals and companies needs to be gradually increased to 5% of GDP. This increment will also take into account strategic collaboration and the use of resources and assets across various stakeholders.

Given the increasing health needs from Malaysia's changing demographics, relying on a single source to support the financing of public health is neither sustainable nor equitable. A form of social compact will be proposed which calls on to share the responsibility of investing in health. As part of this, options for progressive contributory schemes will be explored, deliberated and if found suitable will be presented to the Parliament for bi-partisan acceptance.



The social compact also includes supporting the health needs of the poor. Systematic subsidy and assistance mechanisms involving funding sources such as zakat, waqf, corporate foundations and private philanthropy will also be explored and structured.

Though relatively small compared to total revenues, increasing the application of pro-health taxes<sup>50</sup> as behavioural disincentives, where appropriate, will also contribute towards government funding of health.

The low fees charged by public healthcare facilities is a highly valued feature of the country's health system, allowing affordable access to millions of users. Nevertheless, the one-size-fits-all fee structure has contributed to the immense disparity between fees charged against the cost of provision, as well as the less-noted disparity between the fees charged versus the capacity and willingness to pay<sup>51</sup>, particularly amongst higher income households. To improve the sustainability of public healthcare funding, the range of fees and charges in public healthcare facilities will be reviewed to be more commensurate with different affordability levels, while still maintaining the safety nets and current affordability levels for lower-income households.

The policy intent to increase investments systemically and structurally in health requires securing bi-partisan commitment, which is one of the key objectives of the HWP. Upon endorsement by Parliament, the HWP proposes the following initiatives:

**01** Increase health funding under public sector management gradually to 5% of GDP.

**02** Develop a framework for long-term government funding of health based on benchmarks, demand forecasts and changes in care delivery models.

**03** Review and revision of fee structure at public sector health care facilities.

**04** In-depth technical study, design, and tabling of a sustainable and equitable progressive contributory model for health, including targeted assistance and subsidy mechanisms.

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50 Pro-health taxes are excise taxes on products that have a negative public health impact, for example tobacco, alcohol and sugar-sweetened beverages. It is to reduce the consumption of products deemed risk factors for noncommunicable diseases by making them less affordable through higher prices.

51 Yu, C. P., Whyne, D. K., & Sach, T. H. (2008). Equity in health care financing: The case of Malaysia. *International journal for equity in health*, 7(1), 1-14.

### 3.3.2 Ensuring population receive comprehensive services that are affordable

As part of the social compact proposed above, the progressive increase in health funding needs to be managed effectively towards ensuring Universal Health Coverage, with good quality and at affordable levels.

A benefit package will be developed and established. The benefit package outlines a specified set of services and medications that can be accessed by the population for a standard set of affordable fees with the same level of care, whether the provider is from the public, private or non-profit sector.

The benefit package will encompass a range of evidence-based services, including promotive and preventive services, from primary healthcare up to hospital care, including potentially from digital health providers. The scope of the benefit package will be based on objective economic and health technology assessments and will continuously evolve over time as Malaysia's health financing system matures and in response to changing health needs.

The services utilised by the population under the benefit package will be financed from a dedicated health fund, to be established. The health fund will be financed predominantly by government funding and may include individual contributions and large donors in the future. To ensure that the fund's administration does not burden the public purse and fulfils the public interest, the fund will be managed by the not-for-profit professional Strategic Purchaser governed by clear reporting standards and robust regulatory oversight.

The establishment of a benefit package for the population, financed by a dedicated health fund, will allow for greater pooling of health and financial risk within the population as well as greater cross-subsidisation for Universal Health Coverage. This reform strategy will materially contribute towards reducing out-of-pocket (OOP) expenditure and lowering catastrophic health spending. A professionally managed and well governed health fund will also offer greater structure, transparency, and accountability in this important facet of health expenditure.



Developing benefit package and establishing nation-wide risk pooling via a dedicated health fund are currently at conceptual stages and requires bi-partisan support. Upon endorsement by Parliament, the HWP proposes to follow through on this policy direction as follows:

Designing and developing an essential benefit package matching the needs of the people based on the life course approach.

Establishing a dedicated health fund with clear regulatory oversight to pool risks and enable the fulfilment of services by health care providers to the population.

### 3.3.3 Ensuring effective and efficient healthcare spending

Ensuring the sustainability of health financing not only involves improving investments and funding, but also enhancing the effectiveness and efficiency of healthcare spending. New functions and new strategic practices will be implemented to ensure that increased investments into health result in significant impact on the country's health outcomes.

A not-for-profit Strategic Purchaser will function as the manager of the proposed dedicated health fund. The Strategic Purchaser will be responsible to procure healthcare services from both the public and private sector through innovative and value-based payment models that drive better outcomes, service coverage, cost-effectiveness, quality, and performance from providers. Strategic Purchaser will also be governed by clear reporting standards and robust regulatory oversight.

Effective health spending is also driven by allocative efficiency across different programs, within MOH and across relevant government agencies and ministries. The HWP proposal to transform primary healthcare, strengthen public health functions and stimulate promotive and preventive approaches provides the direction towards better allocative efficiency within the health system. Additionally, periodic reviews will be undertaken to assess whether funding to specific programs, units, departments, or divisions is adequate and well spent in achieving the desired outcomes.

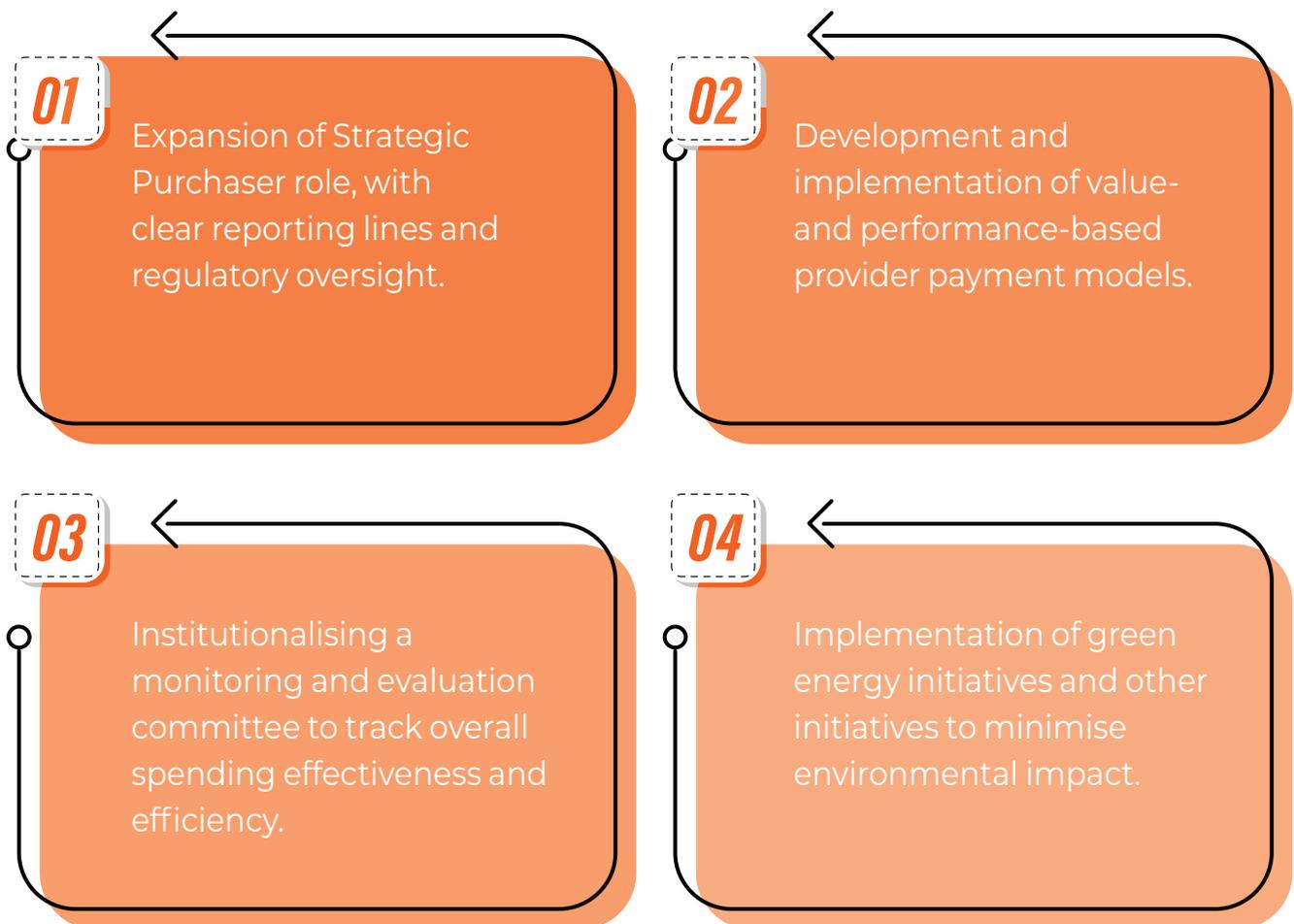


The HWP's proposal to scale-up digitalisation and to increase autonomy for public sector healthcare facilities will contribute towards greater operational and financial efficiencies. To reduce inefficiencies and wastages further, administrative processes and criteria will be reviewed and revised to reduce bureaucracy and improve responsiveness.

Effective and responsible healthcare spending also means recognising the impact of healthcare energy consumption and consumables on planetary health and climate change. MOH will reduce carbon emissions through increased use of renewable energy. The production of pollutants and non-biodegradable waste will be tackled through continuous improvements in medical waste management initiatives.

Improving the effectiveness and cost-effectiveness of health spending will maximise every Ringgit invested into the system to produce continuous improvements in health outcomes amongst the population. The mindset of the health sector will also evolve to be more value- and performance-driven.

Efforts to systematically and structurally improve the effectiveness of health spending are currently either at the early implementation stage or at the planning stage. The HWP proposes to reinforce these efforts as follows:



# From Passive Purchasing to Strategic Purchasing

## What is passive vs. strategic purchasing?

Passive purchasing refers to spending based on the predetermined budget for salaries, utilities, supplies and other inputs.

These 'line items' are typically based on historical spending and cannot move across categories, making the budget rigid and focused on inputs rather than health outcomes.

Strategic purchasing refers to an approach for obtaining healthcare services that continuously aims to maximise value and performance for the amount of funds allocated or available.



## Strategic purchasing requires continuous improvements on 3 sets of decisions:

### A. What to buy?

Identifying the interventions or services to be purchased taking into account population needs as well as evidence of effectiveness and cost-effectiveness relative to different interventions

### B. From whom?

Choosing healthcare service providers that have the capacity, service quality, valid accreditation, cost efficiency and area coverage

### C. How to pay?

Determining how services will be purchased including provider payment mechanisms such as capitation, diagnosis-related groups (DRGs) and pay-for-performance principles

## Why are more UMICs and LICs\* moving towards strategic purchasing for health?

Countries are constantly searching for ways to provide more value for the health funding available. International organisations and research universities have reported on growing evidence that strategic purchasing improves technical and allocative efficiency, equity across population groups and improved financial protection.\*\*

Moving towards strategic purchasing is a long-term and progressive effort involving putting in place network of building blocks working cohesively including interlinked information system, technical data analysis, quality assurance, provider autonomy, performance monitoring and evaluation.

Effective strategic purchasing will strengthen equity, efficiency, responsiveness, transparency and accountability in healthcare spending.



\*Upper Middle Income Countries and Lower Income Countries  
 \*\*Source: Gottret, Pablo; Schieber, George J.; Waters, Hugh R., 2008. Good Practices in Health Financing : Lessons from Reforms in Low and Middle-income Countries. Washington, DC : World Bank.

### 3.4 Pillar 4: Strengthening the Health System's Foundation and Governance

This reform pillar proposes major systemic and structural improvements related to the elements underlying and supporting the functioning of the health system as a whole. These include the functions of governance, stewardship, human resource development and management as well as research. The key principles of this pillar include: reorganising key functions within MOH towards facilitating the long-term health system transformations proposed in the HWP; ensuring health related policies, legislation and regulations based on current needs and challenges; addressing systemic challenges in health workforce planning and development; and ensuring closer linkages between research and innovation with service delivery, financing as well as in policy development and governance.

#### 4 Reform Strategies



#### 3.4.1 Restructuring MOH's role

The restructuring of the MOH's role is a critical component of the health reform and is key to improve efficiency in service provision, management and governance of the health system as well as to reduce duplication of functions and activities. It can also create opportunities for other sectors, agencies and ministries to lead some health related activities that may not need to be led by MOH.

MOH will place more focus on its role of governance, oversight and stewardship through policy making, regulatory and enforcement as well as standard setting for the entire health system.



The roles of provider and purchaser that are currently centralised within MOH will be progressively separated as arm's length entities. The service provider role will be devolved through granting of autonomy to public sector health facilities.

The separation of the provider and purchaser functions from MOH will provide for greater arms-length regulation and check-and-balance which would lead to better accountability. With greater independence from MOH, the performance and responsiveness of the provider and purchaser functions would also be improved, ultimately resulting in better quality and value-for-money healthcare services in the country. Strengthening the remaining governance and stewardship roles at MOH will ensure the health system operates with appropriate direction and oversight.

Efforts to restructure MOH's role span a diverse range of initiatives which are currently at varying stages of planning and implementation. The HWP proposes to follow through on these efforts as follows:

01

Reviewing and strengthening of MOH's policy making functions including on public health and emergency preparedness, workforce management, and other policy areas.

02

Reviewing and strengthening MOH's regulatory functions including public health functions, standard-setting and quality assurance, provider regulation, purchaser regulation and data governance.

03

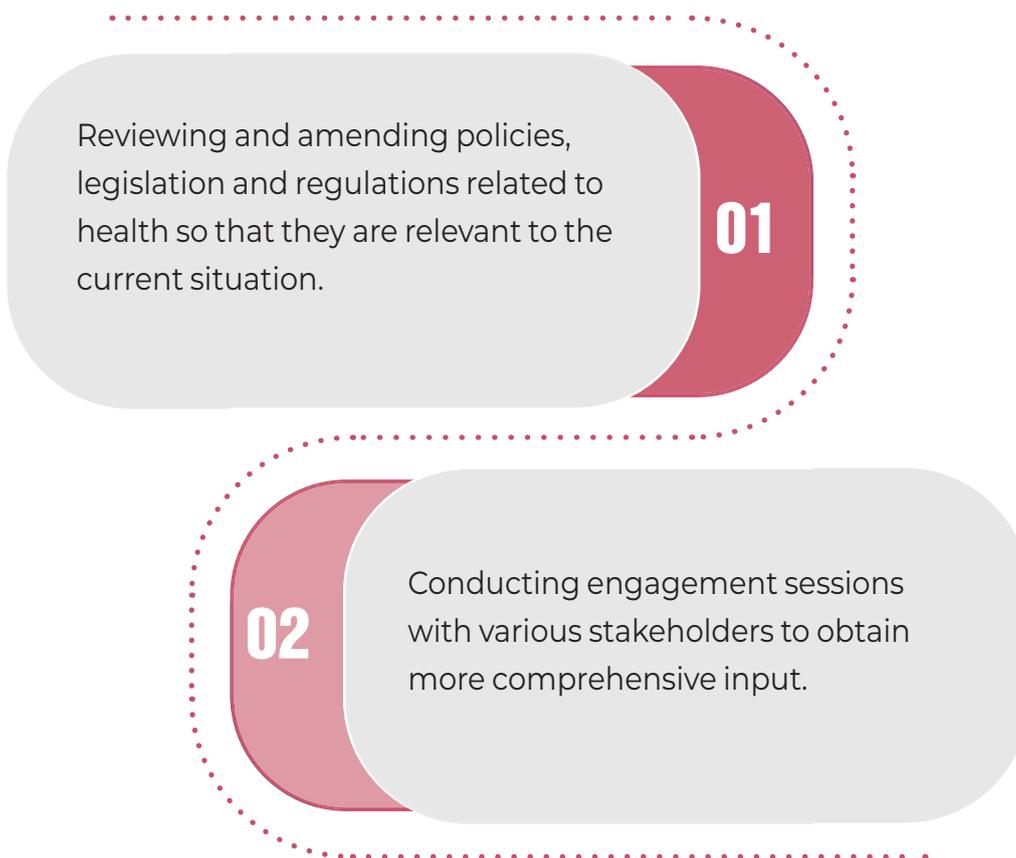
Designing, planning and progressive implementation of public sector provider autonomy initiative.

04

Expansion of the Strategic Purchaser role, with clear reporting lines and regulatory oversight.

### 3.4.2 Strengthening policies, legislation and regulations

Another strategy that needs attention is strengthening existing health-related policies, legislation and regulations. This effort is to improve the efficiency and effectiveness of the national health system based on current needs and challenges faced by the health system. Existing acts, regulations and stewardship systems need to be reviewed to make the health system more flexible and innovative. The regulatory framework, control and supervision activities will also be strengthened especially in the field of newly developing health services. The initiatives that will be implemented under this strategy are:



### 3.4.3 Fortifying the health workforce

Health workforce transformation will need to consider existing challenges such as shortages of staff across various professions, maldistribution of health workers between the public and private sectors, skill mix between regions and service quality concerns, as well as to be future proofed to respond to new challenges brought on by an ageing population, changes in disease pattern, and advances in medicine and technology. Multiple reform initiatives will need to be undertaken to address these diverse challenges.

### ***Education and practical training***

A national framework for professional education will be developed to improve entry requirements, strengthening university accreditation standards and assessment processes as well as instituting regular revisions of the curriculum to keep up with the evolving needs of the health system.

The national framework for professional education will also extend to the continued improvement of in-service training which includes instituting a unified curriculum and competency-based assessment, enabling alternative pathways to obtain practical training as well as strengthening the capacity of trainers and training institutions.

To help address current regional imbalances in health workforce numbers and skill mix, measures will also be taken at the higher education stage. University development programs, admission policies and scholarships need to be fine-tuned to give more rural students access to higher education to address health workforce imbalances and skill mixes between regions.

### ***Licensing and registration***

A standardised professional licensing examination will be developed for medical graduates from both local and international institutions to practise in Malaysia. Measures will also be undertaken to develop common standards, approaches, and processes from various regulations across several health professions to manage the registration and issuance of Annual Practising Certificates (APC) and Continuing Professional Development (CPD).

### ***Public sector deployment, development, and retention***

At the Ministry and policy level, more investments will be made in health workforce training and development, including for allied health professionals, community health workers and social workers towards improving the capacity for delivering person-centred care. To reduce bottlenecks in medical specialisation, accreditation of qualified private hospitals as teaching hospitals will be explored. A rural retention and career pathway will also be developed which may include improved staff facilities, incentives, and training modules to better prepare health workers to serve in rural areas.

### ***Public sector recruitment***

A comprehensive review and forecast of the public sector health workforce will be undertaken towards meeting current and future needs in terms of numbers, professions, skill mix and regional disparities. Projections of job posts will incorporate anticipated changes due to hospital and clinic autonomy initiatives as well as changes in care models towards primary health care, community-based services, and public-private partnerships.

### ***Health workforce in the community***

A new cadre of health workforce will be developed in line with the needs of the ageing society and the concept of healthcare is closer to the community. Close partnership and collaboration with the range of stakeholders and both sectors will be enhanced to enable more systematic coordination amongst the formal health workforce with the larger community of health-related human resources comprising data-driven health researchers, corporates, NGOs, volunteers and caregivers in the community.

The wide-ranging reforms outlined above are aimed at addressing systemic obstacles in producing sufficient, well-trained, competent, and capable human resources to fulfil the nation's health needs today and in future. Initiatives proposed under this strategy are as follows:

<b>01</b> Initiate a supply and demand study of facilities, equipment and workforce capacity for health involving both public and private sectors.	<b>02</b> Implementing a nation-wide health workforce supply and demand plan.	<b>03</b> Bolstering data driven planning and secure investment in the workforce.
<b>04</b> Bolstering workforce governance mechanisms and functions, data-driven decision-making and long-term workforce planning capacity, and secure investment for the production, competency alignment, employment, deployment and retention of existing health and care workers in line with current and projected gaps, inequalities and core health system functions and service delivery needs.	<b>05</b> Recommending a concurrent transformation of undergraduate and postgraduate medical education (this includes doctors, dental practitioners, nurses, pharmacy and allied health) to ensure a fit for purpose health workforce that is future proofed.	

### 3.4.4 Stimulating research, innovation, and evidence-based approaches

Research, innovation, and an evidence-based approach are vital to ensure that the health system becomes more effective and efficient over time. Investments in talent, data infrastructure and technologies will be enhanced as part of a concerted effort to incorporate innovation into service delivery, financing, and stewardship of the health system.

Aligned with health sector digitalisation, systematic data collection from various sources will be improved to enable Artificial Intelligence (AI) assisted big data analytics and data-driven algorithms, which in turn will facilitate disease monitoring, assessment, diagnosis, based on evidence and best practices to deliver effective treatment as well as to improve patient experience.

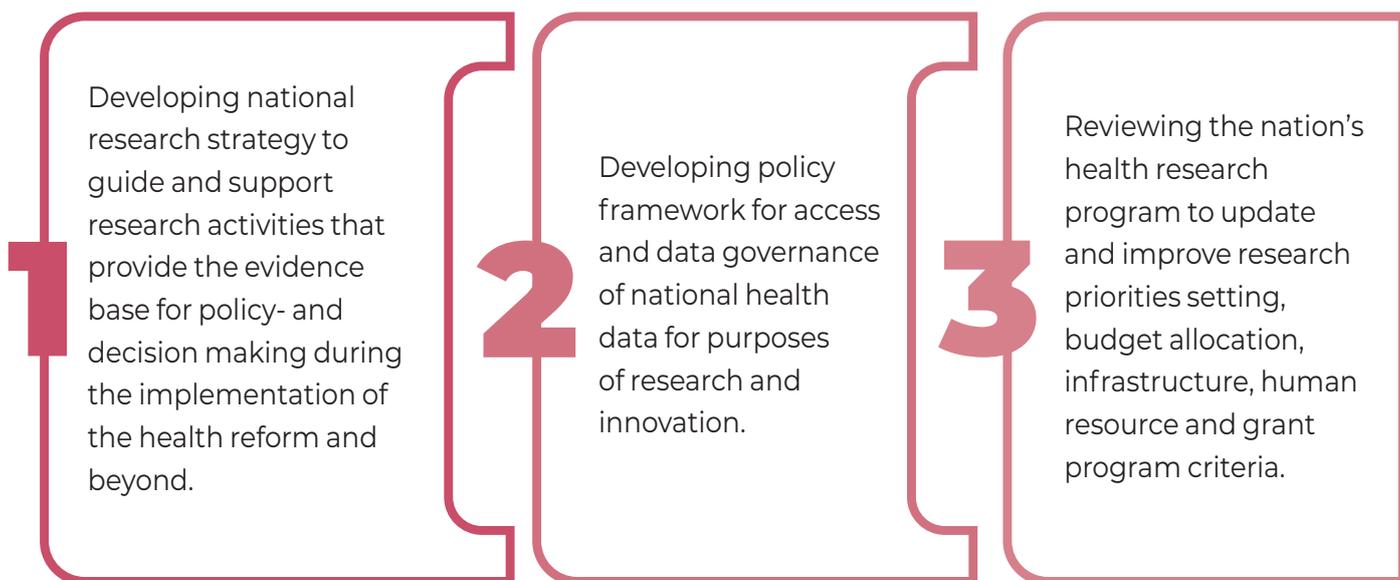
Efficiency and effectiveness in planning, monitoring and decision-making from aspects of governance, resource management and service delivery can also be made immediately with real-time data. Legislation, governance and robust data regulation will be established to facilitate access and sharing of information between the public and private health sectors, as well as to ensure protection, privacy and confidentiality of data.



Policy-making, governance, and stewardship functions at the MOH and other health-related agencies will also be improved by data and analytics, which will inform priority-setting and decision-making in areas from public health programs, emergency preparedness and social care to standard-setting in regulatory functions. Research and analytics of health data will also support the effectiveness and cost-efficiency of health expenditures, driving progressive improvements in the design of value-based payment models to providers as well as progressive expansions in the scope of benefit package.

Apart from strengthening health-related research capability within government agencies, inter-sectoral research collaborations in health will be expanded, both within the country as well as regionally and internationally. Access to national health data by researchers and clinicians will be facilitated in a managed and prudent manner in order to stimulate research and innovation while protecting confidentiality and data security. This will boost the development of the country's health industry such as pharmaceutical industry, medical device industry and digital technology industry.

This reform strategy is a key driver towards producing better health outcomes amongst the population sustainably and continuously, building on information and insights to deliver improvements over time. Efforts to strengthen the health system's research and innovation capacity are as follows:







# Chapter 4

## Reform Phases

Health system reform is a complex undertaking, requiring appropriate phasing of work across a diverse range of initiatives. Some reforms are already in initial or pilot stages but call for long-term Parliamentary commitment to ensure full and resolute implementation, while others need to begin even earlier with detailed technical studies. Some initiatives are standalone, while some are closely linked to or are dependent on the status and pace of other initiatives.

This chapter describes the broad sequencing and estimated time horizons associated with the key health system reforms proposed in the HWP. Subsequently, more in-depth action plans and associated programs will be detailed and implemented.

## Short term horizon (1- 5 years)

The first five years of health system reforms will focus on two forms of activity: firstly, laying the foundational building blocks that will enable the multi-year implementation of complex systemic or structural reforms, including legislative amendments; and secondly, implementing next-stage modules for initiatives that have already begun or are currently in piloting stages to deliver improvements that more stakeholders can experience first-hand, building momentum for broader reform.

### Service delivery transformation



Public health functions, including emergency preparedness, will be reviewed to forecast and update resourcing and coordination requirements including the establishment of a National Centre of Disease Control. Community health volunteer programs will be reviewed to improve incentive structures and impact measurement, including in addressing health disparities amongst vulnerable groups.

To strengthen whole-of-government coordination, the design and implementation of shared health KPIs as well as health budgeting will be undertaken in this period, including the establishment of a Health in All Policies Task Force<sup>52</sup>. This task force will manage the intersections between health care and social care, particularly for the older persons population.

Work to improve whole-of-society coordination on health outcomes will be undertaken progressively, with the development of frameworks for cooperation to tackle specific issues<sup>53</sup> towards ensuring more systematic coordination on the ground.

### Promotive and preventive health



This period will see activities that build on earlier pilots to restructure primary healthcare towards further expanding the establishment of family health teams, enhancing providers' management capacity, increasing the scope of services provided and implementing operational enhancements. A review of resourcing requirements for full implementation will also be undertaken.

This period will see more services being shifted from hospital settings to the community. The focus and performance of public sector hospitals will begin to be addressed structurally with the commencement of the hospital autonomy initiative.

Digitalisation initiatives including the application of EMR and LHR in various in-facility operations and the upgrading of information systems will be piloted and refined before progressive roll-out. Processes to enhance coordination of services across providers, based on digital records, will be instituted.

52 To leverage existing coordination platforms, the Health in All Policies Task Force may be formed as an expansion of an existing cross-agency committee and/or working group. The Taskforce will also be responsible to cross-fertilise and pool ideas on implementing incentives and disincentives via regulations or legislation.

53 For example, specific issues in closing maternal & child health outcome gaps, reducing specific communicable diseases amongst vulnerable groups, and increasing screening and preventive measures for NCDs amongst targeted segments.

## Health financing and expenditure

There will be a progressive increase in government investment in health, accompanied by measures to increase the productivity and effectiveness of expenditure. A proportion of resources will be allocated towards transforming service delivery and strengthening approaches to promotive and preventive health as outlined above.

Work to establish a dedicated fund for healthcare will be undertaken in this period, together with the formal designation and strengthening of the Strategic Purchaser function. Public-private partnerships will be progressively increased to reduce waiting times and to increase patient access with the procurement or leasing of selected services. As part of this initiative, new provider payment models will be developed together with the establishment of monitoring and measurement systems.

To set the country's financing system on a more sustainable trajectory, work to review the public healthcare sector's fee structure as well as to study and propose the structure for a national level contributory scheme will be undertaken in this period.



## System foundations and governance

Devolution of the provider and purchaser role will be substantially realised in this period via the advanced stages of the autonomy initiative as well as the full operationalisation of the Strategic Purchaser role. The legal and organisational structure of autonomous facilities may undergo a change, contingent on a strategic review of the subject which will be undertaken in this period.

Improvements in data gathering and analytics will also benefit MOH's policymaking and regulatory functions. This period will see further incorporation of analytics into decision-making processes towards delivering more impactful policies, balanced regulations, and more effective allocation of resources.

Several key strategic initiatives for the health workforce will be initiated including analysing and mapping of health workforce supply and demand; development of a national framework for professional education of the health workforce; development of a standardised professional licensing examination and credentialing of health practitioners.



## Medium-term horizon (6 - 10 years)

The middle five years of health system reforms as proposed by the HWP will mainly see the next stage or fuller roll-out of initiatives begun in the earlier time frame.

### **Service delivery transformation**



This period will see the expansion of technology-enabled family health teams and healthcare provider networks, involving both the public and private sector, in line with the offering of more comprehensive services to deliver greater person-centred care. Digitalisation and operational improvements begun in the earlier period will be leveraged to improve referrals, follow-ups, and clarity of responsibilities across providers at different levels of care along the care continuum to ensure seamless transitions for the patient.

The hospital autonomy initiative will have completed the pilot stage and therefore this period will see refinements being made to the model together with full roll-out to all relevant public sector facilities. Autonomy of public sector primary healthcare will be more fully tackled in this period.

Digitalisation initiatives involving public sector providers at all levels of care will be fully rolled out in this period, including clinics and hospitals requiring ICT infrastructure upgrades.

### **Promotive and preventive health**



Initiatives undertaken in the earlier period towards increasing the capacity and capability of MOH functions related to the delivery of promotive and preventive health services, including public health and emergency preparedness, will be further improved. Work to improve operations, monitoring and evaluation capabilities will be increased in this period, bolstered by increased capacity in data gathering and analytics.

Whole-of-government coordination will benefit from increased digital and analytical capacities across the entire administrative machinery of government, not only the MOH. This period will see more systematic use of data to support evaluation and delivery efforts on addressing SDHs as well as shared health KPIs.

Whole-of-society efforts will similarly benefit from the increased use of data. This period will see the development of better frameworks to guide the coordination of activities across stakeholders and to improve the allocation of resources across issues and locations.

## ***Health financing and expenditure***



Within this time frame, the continued progressive increase in government investment will be supplemented by funds for targeted assistance from large donor organisations, a revised fee schedule and the potential commencement of a national contributory scheme.

The diversification in sources of health financing will contribute towards the expansion of the dedicated health fund established in the earlier period, which will improve the benefit package that can be offered to the population during this time frame. This time frame will also see continuous improvements in payment models towards achieving more value-based care, including the use of provider incentives to drive better health outcomes.

## ***System foundations and governance***



This period will see further strengthening of professional development, and credentialing developed in the earlier time period.

## Long-term horizon (11 - 15 years)

With the complete or near-complete roll-out of systemic and structural changes in the earlier time frames, the latter five years of health system reforms as proposed by the HWP will see a transition towards health system stabilisation. Initiatives to refine or course-correct earlier work can be expected, but the fundamental shifts in the health system's direction, priorities and organisation would have already begun to take shape.

### *Service delivery transformation*



This period will see refinements to organisational arrangements and processes arising from the establishment of family health teams at the primary healthcare level, including better coordination across different levels of care and across the public and private sectors, such that the health system will feel less dichotomous and fragmented. In acute care treatment, the focus will be given to maintain the health status in the community through regular follow-up treatment, with the use of integrated technology.

This period will see most public sector providers functioning autonomously, and more comprehensive enforcement of service standards on both public sector and private sector providers to achieve more balanced quality and performance levels across the sectors.

### *Promotive and preventive health*



Building on the work undertaken in earlier years, this period will likely see the incorporation of new technologies to improve or adapt ongoing programs and processes. Apart from its use in healthcare settings, the use of wearables, sensors and other devices may be expanded to further improve effectiveness of public health functions such as population risk-profiling or regional monitoring.

## ***Health financing and expenditure***



This period will see the full establishment of institutional, administrative and governance arrangements that enable the diversification of funding sources contributing into the dedicated health fund. The framework for managing the fund, purchasing services, and progressively improving benefit packages would have been in operation for a number of years and therefore, this time frame will likely see refinements in detailed technical or operational aspects such as payment models or assessment criteria.

## ***System foundations and governance***



This period will see the devolution of the provider and purchaser role stabilising.

Fine-tuning of policy frameworks related to health workforce planning, professional education and credentialing will continue to be undertaken in this period and beyond.



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## Chapter 5

# Health Reform Monitoring

In order to sustain our commitment, drive progress, and embrace adaptability, it is imperative to go beyond the boundaries of principles and reform directives. Continuous oversight on follow-through is required to maintain the commitment and pace of implementation as well as to enable any necessary course corrections. An independent monitoring body such as a special task force, committee, council or commission will be established to future-proof the proposed health reforms. This body will establish a check and balance mechanism while ensuring the stability of the health reform reporting process in the political economy environment throughout the reform period and ensure commitment to long-term health reform is maintained and withstand changes to the political and administrative leadership.

The role of this body will be to monitor, advise and report on the status of health reform implementation to the Parliament and the people. This body may suggest course adjustments and strategic changes when necessary. Its membership will represent a range of expertise related to health systems, social protection, and long-term systemic transformation. Terms for its establishment and operations, including resourcing, detailed work scope, size, method of appointment, tenures, reporting lines and others, will be studied, aligned to the Government's policy and further discussed with related central agencies.





# Chapter 6 Conclusion

## **Strengthening the people's health, future-proofing the nation's health system**

Malaysia's health system is at a critical juncture. While there have been relatively good health outcomes for the people historically, the gaps and challenges inherent in the system could stall progress on the nation's health outcomes and achievement of the United Nations SDGs.

There is an urgent need to define a path forward that 'future-proofs' the health system, namely a course of action that lays the building blocks for the long-term sustainability and resilience of the health system, enabling the system to proactively respond to the evolving needs of the population.

The strategic framework for health system reform which may be summarised across four reform pillars as follows:

**Pillar 1: To transform the delivery of healthcare services in the country** by prioritising and restructuring primary healthcare; optimising hospital care; granting operational autonomy to public sector providers and increasing partnership with private sector providers; and harnessing digitalisation and technology for overall service delivery improvement.



**Pillar 2: To cultivate and ground health promotion and disease prevention approaches at all levels** in the nation by improving public health and health emergency preparedness functions; improving processes to drive shared ownership of health outcomes amongst government agencies; improving methods for coordination and collaboration with stakeholder groups in communities and in society; and increasing the application of incentives and disincentives to acculturate healthy behaviours and norms.



**Pillar 3: To place the financing of the health system on a sustainable footing** towards progressively increasing health funding under public sector management; exploring and implementing equitable ways of diversifying sources of health funding; pooling the population's health risk into a dedicated health fund that ensures affordable coverage over a comprehensive set of services; and ensuring the cost effectiveness of health expenditure by instituting a range of organisational and governance reforms including the establishment of value-based payment models and the strengthening of the Strategic Purchaser.



**Pillar 4: To strengthen the organisational, governance and stewardship foundations of the health system** by strengthening the MOH's policy-making, regulatory, data stewardship and research functions; devolving the healthcare provider and purchaser role from the MOH in order to institute greater check-and-balance as well as performance; improving policies, legislation and regulations related to health to be relevant to the current situation; improving the health workforce ecosystem including planning, credentialing, career development, public sector recruitment and deployment; and stimulating research, innovation and evidence-based approaches.



Some of the reform themes contained in the pillars and strategies above gained increased prominence in recent times but many others are not new to Malaysia. Since the 1980s, there have been multiple efforts to address the systemic challenges inherent in the country's health system. While many stakeholders have highlighted the clear need for systemic and structural shifts, long-term change has not been purposefully introduced due to the lack of clear agreement on the direction of reform. This critical component, namely securing broad agreement on the case for change and the path forward for Malaysia's health system, is the purpose of tabling the Health White Paper to Parliament.

The direction of the health system reform pillars proposed by the HWP are sufficiently broad and enduring; nevertheless, reform efforts need to be able to adapt and course-correct in the face of learnings, improved methods or models and new technologies. In that regard, the strategies proposed herein may be refined during the HWP reform period, upon the recommendation of the Government, the health reform monitoring body or Parliamentary Select Committees, after debate and deliberation at Parliament.

Health system reform for Malaysia is necessary and urgent. Reform of the health system is required not just to prepare the system for the future, but to enable Malaysians to live in better health and for the nation to prosper. Before more time is lost, the Parliament, the people and the nation must stand together and begin the journey of health system reform today.

