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Experts Roundtable Report on Malaysian White Paper for Health

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United Nations University
International Institute for Global Health

Hospital Canselor Tuanku Muhriz UKM (HCTM),
Jalan Yaacob Latif, Bandar Tun Razak, Cheras,
56000 Kuala Lumpur, Malaysia

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EXPERTS ROUNDTABLE REPORT

PREFACE

This report presents a summarised account of extensive discussions held on July 2nd about the forthcoming Malaysian White Paper on Health.

The discussions took place over a full day and consisted of a mix of plenary and small group roundtable discussions (see Appendix 1 for the full programme). A total of 54 health policy experts from a wide range of stakeholder groups were invited to participate in the discussions. In addition, there were 10 observers (including from the MoH) and 17 other participants who provided a secretariat function for the event. See Appendix 2 for a full list of all attendees.

The meeting was convened and hosted by the United Nations University International Institute for Global Health (UNU-IIGH) and the University of Malaya Faculty of Medicine, working with and through an organising committee of 10 individuals from various organisations.

Following the meeting, a detailed record of the discussions and recommendations from each roundtable was prepared. These records were then condensed and summarised by UNU-IIGH before being compiled into this single report, along with an integrated executive summary.

The event on July 2nd involved multiple stakeholders covering a wide range of issues and consisted of about 10 hours of cumulative discussion time. This was followed by further email discussions designed to refine and improve the quality and clarity of the written reports.

In summarising and presenting an overview of the discussions, UNU-IIGH has done its best to accurately reflect the discussions and present a succinct account of the key recommendations. However, UNU-IIGH recognises that this report does not represent the views of everyone on every single issue or topic.

Importantly, the discussions on July 2nd should be viewed as only a first step towards developing expert and professional consensus on the broad direction of travel for health reform in Malaysia. Further work is required to generate political, public, and professional support for a reform agenda that will strengthen Malaysia's health system and deliver more effective, efficient, and equitable healthcare.

David McCoy
Research Lead: Evidence to Policy
United Nations University International Institute for Global Health

Indra Pathmanathan
Senior Visiting Fellow
United Nations University International Institute for Global Health

EXECUTIVE SUMMARY

Background to the White Paper for Health

Governments across the world are currently taking stock of their health systems in the wake of the COVID-19 pandemic. The pandemic shone a light on the different building blocks of a health system and the multiple functions of a health system in all countries. There is now also greater public awareness of the importance of health policy and health systems design to the common good, including health security. Malaysia is no exception to this trend and is developing a White Paper aimed at strengthening the health system and safeguarding the population from future threats to health.

But even before the pandemic, there was widespread agreement that the health system needed reform. Although Malaysia's health indicators are reasonable compared to other upper middle-income countries, various studies indicate that improvements in the performance of the health system have stagnated, and in some respects reversed.
Among the widely acknowledged challenges facing the health system are:

- A high level of fragmentation and disintegration across the health system, due to a market-driven expansion of private sector with negative impacts on the public sector and the performance of the overall system, as well as poor communication and integration across the primary, secondary and tertiary levels of the health.
- Inadequate investments in healthcare, with Malaysia spending a low percentage of GDP on healthcare and experiencing high levels of out-of-pocket (OOP) payments.
- A rising burden of non-communicable diseases, which signals insufficient investment in health promotion and disease prevention, low health literacy, and poor multi-sectoral engagement in health promotion and protection.
- Significant inequities in healthcare, both in geographic terms as well as between those with and without access to high quality secondary and tertiary care.
- Increasing pressures on the health system due to rising costs in the pharmaceutical and medical technology sectors, as well as demographic changes producing a higher number of people requiring welfare services and long-term care
- Low levels of morale and motivation amongst large segments of the health workforce.

There is widespread consensus amongst health policy experts that these challenges point to a need for substantial and structural reforms to the financing, governance, organisation, and management of the health system.

KEY RECOMMENDATIONS

Systemic and structural reform will require a carefully designed 5–10-year plan for phased and sequential change consisting of a combination of financial, legislative, regulatory, governance, and organisational changes.

Resource mobilisation

To address the underfunding of health and high levels of OOP health payments, an increase in pooled funding for health is required. Central government revenue is widely accepted as the ideal health financing source for a well-functioning national health system. Furthermore, most economists would state that a higher percentage of GDP can be captured as public revenue, which could in turn generate additional financing for the health sector.

One way to increase general central government revenue is through taxes. These may include goods and services tax (GST), income and corporate tax; mandatory payroll tax; financial transaction taxes; property, wealth and inheritance taxes; carbon tax and a variety of earmarked consumption taxes. Further discussion and work are needed to examine these different options in terms of progressivity, efficiency, amount, political feasibility, and administrative feasibility.

Actions to increase health financing and expenditure must, however, be accompanied by actions to contain cost inflation, improve efficiency, and reduce waste within the health system.

Management of public finances for health

Recognising that trust and openness are important for getting and keeping public support for reforms, one of the most important recommendations is that the government set up a new statutory agency with the power to manage all the public funds for healthcare. This new agency would exist as a para-statal agency with a responsibility for funding and purchasing healthcare in a strategic and impartial manner from both public and private providers. This agency would thereby play a critical role in re-shaping the health system so that there is a more coordinated and efficient use of private and public providers to meet the country's health needs; more effective integration across the primary, secondary, and tertiary levels; and a relative shift of expenditure from secondary and tertiary care to primary healthcare and public health. Further discussion and work are needed to develop the details of this new agency and the mechanisms by which it would function in a strategic, efficient, and transparent manner.

Governance, management, and organisation of health facilities and services

A key aim of the White Paper must be to overcome the inefficient and inequitable public-private divide in the health system, while simultaneously improving the quality and standards of performance of individual public and private facilities and services at all levels of the health system.

To this end, it is recommended that all hospital and other clinical facilities and services currently under the management of the Ministry of Health (MoH) be 'corporatized' on a non-profit basis. These networks of facilities and services would be corporatized under a single entity with 4-5 regional groupings or within 4-5 independent and separate regional entities. Some form of management structure at the district level would be required to integrate and coordinate the different public, private, community, and non-governmental elements of a holistic primary health care (PHC) system and ensure efficient links to secondary care.

Corporatised university teaching hospitals would remain as independent corporate entities. Funding for educational purposes would continue to be provided by the MoE, but it is recommened that health service delivery should be funded through the strategic STC purchasing agency. Corporatised for-profit public hospitals under the MoF, such as the IJN, would continue but also have some of their services purchased by the new funding agency.

While private sector hospitals and clinical facilities would continue to operate independently, the new strategic funding and purchasing agency would identify opportunities to: i) incentivise collaboration between the public and private sectors at primary, secondary and tertiary levels; ii) reduce waste and increase systems efficiency; iii) establish a common health and management information system (HMIS) across the public and private sectors, including personal electronic medical records for the population; and iv) address needs and gaps in the health system. It was also recommended that the strategic funding and purchasing agency use its mandate to incentivize the development of a more preventative and multi-disciplinary model of PHC in the private sector and encourage more effective community involvement in PHC.

Simultaneously, MoH will continue its strategic and policy leadership role in the health sector, strengthen and expand its current public health remit, and drive the intersectoral coordination needed for health promotion and protection. This will include continuing and strengthening its role as a regulator and steward of the health system through monitoring the performance of all corporatized facilities and services according to explicit and improved standards of clinical care and financial management, as well as population-based health improvement targets. The MoH will also continue and strengthen its role in regulating and monitoring the private sector, ultimately bringing coherence to the monitoring and regulation of the new not-for-profit corporatized agencies and the for-profit private sector agencies with comparable and appropriate expectations in terms of quality, outputs, and impact for services funded through the purchasing agency.

Human resources for health (HRH)

Health workers are the lifeblood of any health system. There are, however, multiple problems and systemic deficiencies in the way in which health workers are produced, deployed, and remunerated. Systemic reforms are required to bring coherence to Malaysia's public and private health workforce production systems. A high-level multi-stakeholder HRH Board chaired by a senior Minister or the Prime Minister should be established with the authority to synchronise HRH production and deployment across the Health and Education and related sectors (public and private). This Board would have a dedicated secretariat responsible for collecting and analysing HRH data in a regular and timely manner and producing strategic plans for HRH development and management.

Whole-of-society approach

The White Paper should advocate for stronger mechanisms to build buy-in and ownership from key actors for a comprehensive and multi-sectoral health agenda.

Next steps

This report only provides broad recommendations at a high level. However, further discussion and more work are required to develop the detailed proposals and plans that would be required for successful reform.

It's also important to note that all health systems have a high degree of intrinsic inertia and resistance to change, as well as actors with vested interests who may oppose change. It will therefore be important to: i) generate bipartisan political commitment for the reform process; ii) ensure strong technocratic leadership to lead on the details of the reform process; and iii) build trust and support with the public and the health workforce, and clearly articulate how reform will benefit the taxpayer, patients, the PHC workforce and the country as a whole.

Health Financing: Resource Mobilisation

Scope of discussion

This roundtable focused only on the first of the key health financing functions—resource mobilisation.

The key questions posed to the expert panel were:

- What are the potions for increasing healthcare finance over a 2 to 10-year horizon?
- How feasible would each of these options be?
- What risks do they entail?
- How can these risks be mitigated?

As a diversity of opinions was expected from the expert panel, consensus was not sought. Rather, various options for increasing resource mobilisation for health were discussed.

Starting points

- There is wide consensus that health is underfunded in Malaysia relative to its level of economic development, disease burden, and the aspirations of its citizens. Compared to countries with a similar Gross National Income (GNI) per capita, the magnitude of underfunding is substantial: ~ low RM 10s of billions per year; low single-digit percentages of Gross Domestic Product (GDP), or around an additional 10 per cent of general government expenditures.

- Out-of-pocket (OOP) health spending is high [35% of catastrophic health expenditure (CHE)] and undesirable due to issues with inefficiency, equity, and financial protection. Hence, a strategic aim of health financing reforms must be to reduce the percentage of OOP health spending by increasing the proportion of pooled health financing.

- Health financing should be progressive, with wealthier segments of the population contributing a higher proportion of their income/wealth to health financing.

- Health financing should be sustainable, and investments in the health system should contribute positively toward broader social, economic, and industrial goals.

- Additional resource mobilisation and wide pooling of financing for health require those making contributions to trust that their contributions will be managed effectively, efficiently, and ethically.

Key points about terminology

The roundtable identified two critical sources of misunderstanding and miscommunication that should be avoided.

Outdated views about the difference between social health insurance and general taxation models

An important outcome of the roundtable discussion was an improved recognition that the difference between so-called social health insurance (SHI) financing models based on a payroll contribution and general tax-based funding may not always be as large as it is made out to be. Payroll contributions and tax-based funds may, for example, be blended into a common pool. For example, while the United Kingdom National Health Service (NHS) is predominantly tax-funded, about one-fifth of its financing comes from a mandatory payroll tax (National Insurance).

Similarly, the SHI systems in Germany and France rely on general government tax revenue to expand coverage provided through payroll contributions. To quote a recent paper[1]: "we are seeing a blurring of institutional and other differences between systems that were previously separately classified as being general tax-financed vs SHI-financed models of health financing. Several general tax-financed health financing systems now include elements – e.g., strategic purchasing of health services and a purchaser-provider split – that were previously considered to be hallmarks of SHI-financed systems. And SHI-financed systems are increasingly becoming dependent on complementary general tax-financed sources especially for subsidizing financing of coverage for the poor, unemployed, and retired populations."

Lack of clarity around the term "insurance"

It was also noted that the term 'health insurance' may be easily misunderstood because the term covers many different forms and models of insurance including:

- narrow schemes that cover only rare and/or high-cost treatments, or comprehensive schemes that also cover essential primary health care.
- private voluntary health insurance as well as national or social health insurance.
- private for-profit schemes managed by businesses, as well as non-profit schemes managed by governmental agencies or non-profit organisations.
- schemes where insurance premiums and benefit packages are set for individuals with no risk sharing (i.e., where individuals may fear losing insurance cover if they lose their jobs or cannot pay premiums) and schemes where insurance premiums and benefit packages are set for populations (i.e., where individual risk is shared and cross-subsidisation enabled).

[1] General Taxation and Social Health Insurance. Ajay Tandon, Christoph Kurowski, David B. Evans. Draft pending publication.

Principles

Given Malaysia's health financing context, several key principles were discussed:

- There should be no reduction of Malaysia's existing general government revenue-anchored health financing. The roundtable focused on increasing pooled and public sources of health financing that would supplement the current portion of general government revenue allocated to health. Additional pooled and public financing for health could come from a diversity of sources.
- Malaysia's level of general government revenue as a percentage of GDP is currently low and should increase to be comparable with most other middle-income countries.[2]
- There are many factors to consider when advocating an increase in general government revenues relative to GDP.[3] But trust and public support are critical for any increase in public revenue.
- Health is a public good with large externalities and large societal returns on investment. The role of the government is fundamental. The COVID-19 pandemic has clearly revealed the criticality of continued public investments in health.
- Sustainable health financing should not be equated with more private financing or a reduction in the government's role to create national pools of public finance.
- While macroeconomic trends may not allow an expansion of public financing for health in absolute terms, it may allow for public health financing to increase in relative terms as a percentage of GDP.

Options for mobilising resources

There were different views expressed as to how: i) additional resources could be mobilised to increase health expenditure; and ii) how resources could be mobilised to reduce the high proportion of OOP payments. Some advocated that the health community should set the government a target for the desired level of healthcare coverage and that the Ministry of Finance (MoF) should be left to determine how best to raise the required revenue. Others gave specific recommendations for how additional revenue could be generated. What follows is a summary of recommendations grouped under three headings. First, were recommendations related to central government revenue. The second is recommendations related to SHI. And the third is related to recommendations for raising additional revenue through efficiency gains.

Approaches and options for resource mobilisation from general government revenue

- Central government revenue is widely considered the ideal health financing source for a national health system, enabling equitable health financing, optimal risk sharing, and economies of scale. General government revenue is currently the single largest source of financing and was the anchor for Malaysia's precocious success in rapid and improved maternal and child health outcomes.

- Governments may raise revenue through a variety of means. These include taxes and income generated by government-owned industries. As noted earlier, it was recommended that the government capture a higher percentage of GDP as public revenue, and that could generate additional resources for the health sector, with or without increasing the allocation of general government revenue to the health sector.

- It was recommended that a health expenditure target should be set for the next five to ten years to allow for planned growth. This would be formulated by the MoF in consultation with the MoH. Options for setting an expenditure target may be based on either bottom-up costings of what would be required to achieve a desirable level of universal healthcare coverage, or based on a proportion of GDP (e.g., 5% of GDP). The latter may include a moving or progressive target whereby the percentage of GDP allocated to health increases as the country develops economically.

- It was noted that any new or increased streams of government revenue for health would need to be strongly linked to a credible political commitment to use the extra revenue to expand the breadth and depth of health services that would be fully or partially financed by the public purse. Both the MoF and the MoH would need to justify these new or increased revenue streams, especially if they involve an increase in general taxes.[4]

- The roundtable also agreed that any increase in central government revenue be generated in ways that are progressive and not harmful to labour markets and working people relative to capital. The roundtable also agreed that financing should "correct" some of the past favourable handouts to corporations and overzealous privatisation.

- There are various potential sources of new or increased central government revenue, as shown below. These include sources of revenue that would flow into general government coffers as well as sources of revenue that could be ear-marked specifically for health. The potential sources of new or increased central government revenue are:
  a. GST
  b. Income tax - increase or expand
  c. Financial transaction taxes (e.g., on currencies, stocks, and derivatives)
  d. Property, wealth, and inheritance taxes
  e. Corporate taxes
  f. Carbon tax
  g. Earmarked consumption taxes: i) health taxes on tobacco, alcohol, sugar-sweetened beverages (SSB), and gambling; ii) carbon tax; iii) luxury consumption taxes.
  h. Other sources: wakf, zakat, and other religious donations

- There are pros and cons attached to each of the above sources of government revenue in terms of progressivity, efficiency, potential volume, political feasibility, and administrative feasibility. Further research and discussion are needed to identify the best ways forward for increasing government revenues in general and specifically for health.

- It was noted that health taxes (sometimes known as 'sin taxes') only raise a modest amount of revenue and are usually advocated because they can reduce unhealthy behaviour. It was also noted that Malaysia's use of health taxes is low or limited in comparison to other countries. Similarly, carbon taxes are also being strongly advocated by many economists because of their ability to help reduce greenhouse gas emissions.

[4] The roundtable did not determine how any increased allocation of general government revenue to health would be managed. This could be done using the existing MOF line-item budgeting system to the MoH, or through a new or different agency.

Resource mobilisation through an ear-marked and mandatory payroll contribution

- Given that some individuals and corporations already voluntarily spend funds on private health insurance and employer-provided health coverage, an ear-marked mandatory payroll contribution from formal sector public and private employers and employees was suggested as an additional method for mobilising health resources. It was also noted that when investments in health are effective and well designed, they can improve workforce productivity and bring added value to employers and employees.

- The details of a mandatory payroll contribution to a health fund would still need to be worked out. But it was suggested that: i) the size of the contribution should be progressive and modest to minimise labour market impacts and the unfairness of a tax on labour (rather than capital); ii) there be no opt-outs (or reduction or percentage reduction) allowed for those who choose to purchase their own private health insurance; iii) opt outs for either B10 or B40 groups be considered; and d) existing collection systems [e.g., Lembaga Hasil Dalam Negeri, Social Security Organization (SOCSO), or Employment Insurance System (EIS)] be considered.

- No specific proportional contribution between the employer and employee was recommended.

- It was also felt that these mandatory contributions should contribute to universal health coverage rather than to a segmented and separate financing platform for those in formal employment. This would also avoid the extra administrative costs associated with a dedicated SHI fund running in parallel to other sources of pooled finance. However, as these funds would be 'hard ear-marked" for health, they would not be channelled through the federal consolidated budget, but to a dedicated health financing and purchasing institution.

Improving efficiency

It was repeatedly stipulated that any increased health financing and expenditure must be accompanied by mechanisms to contain costs and improve efficiency. Malaysia's current context is that of undertreatment of NCDs at the population-level, stagnant or worsening health outcomes and inequalities, and high out-of-pocket expenditures. Hence, cost containment should not be focused on limiting access or increasing recovery of out-of-pocket expenditures (i.e., doing less), but on improving the efficiency of the health system (i.e., more bang for the buck). General suggestions:

- Improve allocative efficiency: Strongly emphasise prevention and comprehensive primary health care; purposefully de-emphasise hospital-centric care; strengthen the health technology assessment process to ensure a benefits package which prioritises and guarantees equitable access to a minimum of highly cost-effective interventions, especially prevention-focused and primary health care interventions.

- Improve technical efficiency: Strategic purchasing and the use of appropriate and advanced provider payment mechanisms; a shift towards more performance-based payments; expose, over time, the public and private sectors to greater competitive pressures.

Health Financing: Management of Resources

Scope of discussion

This roundtable discussion was a follow on from the roundtable that discussed resource mobilisation.

The key questions posed to the expert panel were:

- How should public finance for health be governed and managed and by which entity?
- What reforms are needed to the way funds are budgeted and allocated?
- What reforms and changes are needed to improve provider payment mechanisms?
- What reforms and changes are needed to improve the containment of costs?

The following key themes emerged from the discussion.

Governance of public finance for health

The organisation, governance, and management of health financing exert a considerable influence on how the health system delivers on equity and efficiency.

The roundtable discussed several suggestions for how public finance for health should be managed. It is, however, recognised that the Ministry of Health (MoH) has overall responsibility for stewardship of the health system and plays a key role in improving synergy and coordination across the public-private divide and ensuring optimal systems-wide performance.

To do this, a key recommendation was that the government establish a new statutory agency with delegated powers (new legal provisions may be needed) to manage the public funds available for healthcare. It was suggested that such a para-statal agency would extend beyond the current remit of the MoH and have responsibility for managing the public finance for health care or health-related services that is currently channelled through other ministries. The rationale behind this suggestion is that a funding agency that is at arms-length from the MoH would be more independent and able to purchase healthcare in a strategic and impartial manner from both public and private providers. In other words, this recommendation promotes a more explicit purchaser-provider split.

Given the constitutional responsibility of the MoH, this new agency would need to have some ultimate accountability to the MoH. It was also suggested that the agency could be accountable in some way to a parliamentary committee or the Prime Minister's office. Another remark was that this new agency should be

responsive or accountable in some way to a governing body with representation from a variety of stakeholders such as MoH, representatives from Treasury, Ministry of Labour, unions (including nurses and allied health professionals), employers' federation, corporate sector, Malaysian Medical Association (MMA), Association of Private Hospitals Malaysia (APHM), civil society representatives, medical faculties, and allied training institutions.

Budget allocations

The roundtable participants reasserted the principle that health budgets should be allocated according to population health needs and the financial and investment requirements for the delivery of programmes and services. A mapping of expenditure patterns, healthcare utilisation patterns, and health needs was recommended so that a detailed assessment could be made about where and how resources should be shifted within the health system. The collection of this data—covering both the private and public sector—should be mandated and updated on a regular basis.

The roundtable also agreed that resources and investment should be shifted more towards health promotion and disease prevention and away from the current emphasis on curative care. Prevention strategies and public health activities should be enhanced and be given more priority across the care continuum, from primary to tertiary care.

Resource and budget allocations could also be accompanied by value-based evaluations of health service provision, as advocated by the WHO and the World Bank, and not only rely on outcome-based indicators.

Provider payment mechanisms Cost recovery

The roundtable noted the different provider payments systems across the public and private sectors. Line-item budgeting is a dominant provider payment mechanism in the public health sector, while fee-for-service (FFS) is common in the private health sector.

A majority of roundtable participants agreed that public purchasing of healthcare from public and private providers should be based on a common provider payment system. This might include a hybrid of case-mix and disease-related group (DRG) reimbursement systems and/or capitation. A mixed provider payment system could be designed to create incentives and disincentives to enhance the quality and performance of care while keeping cost inflation in check.

It was noted that any strategic purchasing of healthcare, especially from the private sector, would need to be linked to information systems capable of monitoring provider performance and population health needs. Furthermore, both demand-side (cost-sharing, gatekeeping provisions, and referral rules) and supply-side (distribution of providers, quality of care) measures should be considered in purchasing and provider payment.

Cost recovery

Entitlements to healthcare should be carefully designed, taking into consideration the need to ensure access for the B40 population to essential drugs and services.

It was felt that some element of cost recovery should be considered to generate revenue, improve equity by selectively charging the wealthy, and reduce unnecessary demand for healthcare. The current cost recovery system is negligible and not sustainable.

However, the roundtable agreed that no fees should be applied to basic and essential health care, and that most other primary health care, including preventive care, should be accessible to most of the population for free or for a nominal fee. For costly services, a minimum co-payment could be considered, with higher levels of co-payment for wealthier groups.

Data and information management systems

Effective governance and management of health finance requires a good and reliable health management information system (HMIS). It was noted that there is a lack of data and information about the private sector. It was also noted that, in general, Malaysia has an abundance of data but lacks integration and real-time response.

A key priority for the White Paper should be establishing a comprehensive HMIS as well as a multi-sectoral data framework encompassing multiple ministries. The latter would enable a comprehensive and whole-of-society approach to health planning. The principle of transparency was also highlighted—the sharing of data and information between the MoH, researchers and academicians, as well as between public and private institutions, is fundamental to improving the overall performance of the health system.

It was suggested that the current underutilisation of data is due to a lack of analytical capacity and that this would need to be addressed collectively by the Ministry of Health, non-governmental organisations (NGOs), and academicians.

Cost Containment

Effective cost containment strategies are crucial in achieving the vision of future-proof healthcare financing. It was suggested that more effective strategic purchasing of healthcare services from the private sector through "contracts" would be one way of achieving this. It was also recommended that public sector providers be granted greater autonomy, responsibility, and incentives to control costs.

Other mechanisms for cost containment that were not discussed in detail include health technology assessments and greater use of economic evaluations such as cost-effectiveness, cost-utility, and cost-benefit analyses. Another possible strategy is to make use of Certificates of Need, a regulatory process that requires healthcare providers to get state approval before building certain types of facilities or offering new or expanded services.

The roundtable participants suggested that medical inflation could also be contained by economies of scale and bulk purchasing of drugs, equipment, and other commodities at the national level, or even at the ASEAN regional level with other countries. It was also suggested that Malaysia increase its manufacturing capabilities for pharmaceutical products and produce local indigenous drugs that are lower in cost. To help with this, collaborative platforms for research and development should be established with other countries.

Primary Healthcare

Scope of discussion

Primary health care (PHC) was defined comprehensively. The scope of discussion covered health care by various types of health professionals in clinic, community pharmacy, and community settings, including maintenance and promotion of health 'from the womb to the tomb', prevention of disease and disease complications, treatment and management of illness, rehabilitation, and palliative care.[5]

Background

In the past, Malaysia's primary care and public health have been key contributors to improving the health status of the population. However, over the past few decades, the primary health care system has been faltering.

Patients with conditions like diabetes, asthma, and hypertension who should be managed in primary care are ending up in hospitals, requiring expensive care and losing years of healthy living, and premature mortality rates from non-communicable diseases (NCDs) are the highest in the region.

A central reason why the PHC system is faltering is because the structure of the PHC system is fragmented, poorly organised, and inadequately managed. In particular, the PHC system suffers from a lack of integration and coordination between the public and private sectors. Worse still, competition between the private and public sectors creates perverse incentives and poor communication. This results in significant inefficiencies, a lack of continuity of care for patients and a disorganised interface between primary care and public health, as well as between primary care and secondary care.

The model of PHC provided in the private sector is also outdated, being largely composed of single-handed general practitioner (GP) practices. As such, they do not provide a multi-disciplinary model of primary care. This results in an over-medicalised primary care service and an under-utilisation of other health professionals like pharmacists, nurse practitioners, and psychologists, as well as allied health workers such as physiotherapists and nutritionists.

Another reason why the PHC system is faltering is that expenditure on Primary Health Care has not kept pace with Secondary and Tertiary Care. Furthermore, the private primary care system is heavily reliant on out-of-pocket (OOP) payments, which is a regressive form of healthcare financing and impedes efficient and appropriate health seeking behaviour.

[5] Note: some elements of PHC are also delivered in hospital settings

Although the public sector has done a fairly good job of ensuring an equitable distribution of resources, some rural and remote parts of the country remain significantly under-resourced. The maldistribution of public resources is compounded by the fact that private sector GPs and community pharmacists are heavily concentrated in the big urban centres along the west coast.

Large numbers of people are also excluded entirely (refugees and undocumented migrants). They need to be reached for both humanitarian and public health reasons.

A final weakness is that a large proportion of the population is not empowered to adopt optimal health seeking behaviour. Too few are aware of the importance of preventative measures, never mind being enabled to adopt healthier diets and behaviours.

Priorities for reform of the Primary Health Care system

- Address the structural weaknesses inherent in the dichotomous Public-Private split.
- Modernise PHC by establishing a model of care that is comprehensive, multi-disciplinary, and population based.
- Reduce inequities by increasing supply of PHC to underserved and unreached communities.
- Strengthen health literacy and health promotion components of PHC.
- Address emerging needs, with particular reference to the growing burden of mental illness, adolescent ill health, elderly healthcare needs, and the rising frequency of acute emergencies.

Key Outcomes of the Discussion

The expert group reached a high degree of consensus that 3 fundamental changes are needed.

First, change the way primary care is organised and delivered. In particular, the separate public and private systems need to be better integrated into a more unified and coherent system; and the model of PHC should be modernised to adopt a more preventative and multi-disciplinary approach. While individual elements of the PHC system may be working well, the system as a whole is not functioning effectively or efficiently. All this calls for systemic and structural reform rather than a piecemeal approach to change.

Second, increase the absolute and relative allocation of resources to primary care, recognising that enormous savings would be achieved by managing ill-health before it reaches the doors of hospitals. It was also acknowledged that resources needed to be allocated more equitably geographically. The impact of this shift in budgets and expenditure on the secondary and tertiary sectors would need to be considered.

Third, strengthen the role of households and communities in delivering PHC. A strong body of evidence points to active and appropriate community involvement as a key ingredient of effective and efficient PHC systems. Such involvement needs to be organised and actively facilitated by the wider PHC system.

Recommendations

Systemic and structural reform will require a carefully designed 5-year plan for phased change. This would include a combination of financial, legislative, regulatory, governance, and organisational changes, recognising the different needs and capacities in different regions of the country.

Bipartisan political support and strong technocratic leadership will be needed to overcome inertia and obstacles to change. Clear communication of how reform will benefit the taxpayer, patients, and the PHC workforce will also be important.

Elements of a comprehensive PHC reform plan

Integration of public and private providers

A key objective is to develop mechanisms whereby the resources of both the public and private sector can be harnessed as different parts of a more unified and coherent PHC system. The most feasible way to do this is to establish a comprehensive, robust, and effective system of public contracting with private providers. Such a contracting mechanism would include requirements and incentives for private PHC providers to institute clinical and management information systems to allow appropriate monitoring and evaluation; and agree to jointly-developed clinical protocols, guidelines, and standards, as well as quality assurance processes.

The contracting mechanism would incentivise small or single-handed GP clinics to move towards larger organisational groupings capable of making efficiency gains through economies of scale and sustaining multi-disciplinary models of care. It would also enable cooperation and the creation of positive synergies and complementarities between private, public, and NGO providers.

A taskforce should be established to work out both the general approach to contracting as well as the details with respect to price setting, provider payment mechanism, trust-building, as well as monitoring, evaluation, and performance management.

Governance and management

Moving from a fragmented and dichotomous PHC system towards one that is more integrated and coherent would require careful attention to the establishment of the right legal, governance, and management structures. This would include a clear definition of mandates, roles and responsibilities for financial contract management, monitoring and evaluation, and health planning across the federal, state, and district levels; relevant ministries; and between the public and private sector.

Management structures at the district level are especially important for improving the routine interactions (including patient and information flows) between PHC and secondary hospitals, as well as between PHC and community-based services and social services, and between the public and private sectors. These structures would also institute the measures needed to improve coordination between health and social service authorities across relevant ministries and NGOs to address specific health needs for mental health, adolescents, the elderly, and special needs groups.

Recommendations Resource allocation for PHC

Systemic and structural reform will require a carefully designed 5-year plan for phased change. This would include a combination of financial, legislative, regulatory, governance, and organisational changes, recognising the different needs and capacities in different regions of the country.

Pooled finance for PHC will flow through directly allocated budgets to public sector PHC clinics and centres and private sector contracts. The idea is that these funds would be managed in a more integrated manner. In addition, reforms are needed to promote a more strategic and needs-based allocation of resources to ensure that the PHC system develops in a manner that is equitable and based on the particular needs of different parts of the country. This would cover both clinical services as well as community-based interventions, as well as capital and recurrent spending.

Needs-based planning and resource allocation mechanisms could be organised and centred around health districts. Integrated planning at this level would allow for plans that are context-based and provide a platform for coordination between public and private providers. These plans can then be used by budget holders at the federal and state levels to allocate resources more effectively.

Health workforce (HW) development and planning

While digitalisation and technological advancements can help improve the quality and accessibility of PHC services, a competent, motivated, and well-distributed PHC workforce is crucial. A long-term strategy for PHC workforce development is needed. This would cover various aspects of HW development and management, including HW production, training standards, remuneration, and delegation of roles and responsibilities across the different cadres.

Health and management information systems

While digitalisation provides opportunities for improved information management (of individuals, facilities, services and populations), digital information systems will need robust governance structures and mechanisms to protect confidentiality and to prevent the misuse of health data, while still providing access to health information across sectors and geographical boundaries.

Population based data is also an important element of an effective PHC system. For example, addressing the health needs in pockets of urban poverty requires population data disaggregated to postcode levels, as well as better community level understanding and linkages.

Shared health goals and improved communication between health authorities and employers, immigration authorities, and local authorities would also help reduce health risks posed by undocumented communities and migrant labour and improve their productivity.

Hospital Sector

Scope of discussion

The hospital sector in Malaysia consists of secondary and tertiary care (STC) public and private sector facilities providing both inpatient and outpatient care.[6]

This includes acute as well as long-term care and day care but excludes facilities for elder care.

The focus of this roundtable discussion was on governance and financing options to solve the following issues related to the hospital sector in Malaysia:

- Geographic and financial accessibility to hospital care
- Quality of care
- Linkages between hospitals and other parts of the health system
- Health tourism
- Synergy between the public and private sectors

Background

The hospital sector has changed dramatically over the last four decades. Although the public sector still owns the largest share of hospital beds in the country, there has been a steady increase in private hospital bed shares since the 1990s. In 1990, 14.1% of all hospital beds were in the private sector; by 2020, the figure has risen to 35.5%, with more than half of these private beds owned by Government-linked Companies (GLCs). Over the same period, public hospital beds have increased by about half, but private beds have more than doubled. Despite this however, the share of private hospital admissions has remained relatively stable over the past few decades.

As a share of total health expenditure, the hospital sector has also been growing relative to primary health care and public health, increasing from 48.3% in 1997 to 55.3% in 2019.

The increasing privatisation and expansion of the hospital sector (mainly driven by increased private hospital development) has been accompanied by increasing challenges related to accessibility of care (both geographic and financial), quality of care (both patient experience and clinical outcomes), and effective and efficient linkages with other care providers, including social services.

[6] Outpatient care provided by hospitals may include OPD departments providing primary care as well as specialist clinics providing secondary or tertiary care.

There are significant social inefficiencies in the private sector, with, for example, the low use of imaging equipment and services as well as supplier-induced demand for services that are not clinically indicated or evidence-based, with commercial medical technology advancements creating inflationary pressures and challenging the ability of the health systems to provide equitable access to secondary and tertiary care. Added to this are concerns about the negative impact of health tourism on the wider health system and its economic benefits to the taxpayer and country.

There are also systemic inefficiencies across the health system, with poor coordination between primary, secondary, and tertiary care, as well as within and between the public and private sectors. Approximately 14.6% of hospital admissions in 2014 were for conditions that could have been managed through primary care services. The lack of integration between healthcare and social care, particularly for older adults, also leads to unnecessary care in hospitals.

Key recommendations

There was general consensus on the fundamental recommendations, although the details were more contested and will require further stakeholder discussions. Items on which there was general consensus are as follows:

- The hospital sector as a whole in Malaysia requires systemic reform in order to achieve the 'Triple Aims' of the Institute for Healthcare Improvement [(i) improved quality of care for patients; (ii) better population health; (iii) lower per capita cost of healthcare], as well as [(iv) more job satisfaction for health workers; (v) improved health equity].[7]

- Inefficiency, duplication, and waste across the hospital sector – especially in large urban centres on the west coast of the peninsula – requires the MoH to find ways to harness the resources and capacity of both the public and private hospital sectors and improve linkages between various levels of healthcare to meet the health needs of the country. The government can do this through the funding and strategic purchasing of appropriate services from both the public and private hospital sectors, while simultaneously reorganising primary and secondary care facilities to provide adequate and effective care based on health needs for the population.

- It was suggested that the government establish a non-profit para-statal or independent agency with delegated powers to strategically purchase STC from both public and private hospitals (as well as from PHC facilities and services). Improved strategic purchasing would allow the resources and capacity of the private hospital sector to be better harnessed and used in a manner that is complementary to public hospitals.[8]

- ·A strategic public purchasing agency designed to bring greater coherence to STC that would: i) ensure minimum standards across all hospitals; ii) improve public awareness of where they can seek different types of healthcare services; and iii) enable hospitals that are struggling to be improved rather than be penalised if it is in the public interest.

[7] The IHI has also noted that the Triple Aims are about patients and that as most healthcare organisations have not fully achieved the Aims, the focus should not be lost and that what matters has to be measured.
[8] As an initial measure, the public sector could increase its purchase of under-utilised services in the private sector where there is unmet need for such healthcare and insufficient capacity in the public sector e.g., radiotherapy, imaging, and dialysis.

- An up-to-date mapping and audit of all hospitals in terms of their financial and clinical performance; services provided and utilisation patterns; availability of equipment; staffing mix and levels; adherence to quality and safety standards; and capital investment needs would be a central requirement for effective strategic purchasing.

- Presently, private and public hospitals vary in terms of ownership; size; governance and financing arrangements; operating environment (e.g., some hospitals operate in competitive markets while others do not); and employment practices. Reforms to the governance and management of these different types of hospitals are suggested as follows:

    a) Public hospitals and other patient care facilities currently under the direct management of the MoH would be incorporated into one or more new 'corporate' not-for-profit para-statal agency/agencies. One suggestion was to have a single corporate entity with the authority to manage all these facilities within four to five regional groupings to allow for greater responsiveness to local priorities and needs and for representation from various states in the groupings. Another option was to have four or five regional corporate entities that are independent of each other.

    b) Corporatised university teaching hospitals, which are currently fully funded by the Ministry of Education (MoE), would remain as independent corporate entities. Funding for educational purposes would continue to be provided by the MoE, but health service delivery would be funded by the strategic STC purchasing agency.

    c) Corporatised for-profit public hospitals under the MoF, such as the National Heart Institute, would continue as such but would have some of their services purchased by the new funding agency.

    d) Private hospitals and non-government hospitals would be managed independently and would also have some of their services strategically purchased by the new funding agency but be subject to stricter adherence to the Private Hospitals and Health Services Act 1996.

- The status of private hospitals owned by GLCs as profit-making entities should be reviewed on the basis that this creates a perverse incentive for the government to benefit financially from high private hospital utilisation rates.

- The creation of a new corporate agency to manage public sector hospitals (and PHC facilities and services) would allow the MoH to focus, expand, and strengthen its ability to monitor and regulate hospitals; work with Malaysian Society for Quality in Health (MSQH) as the designated body for hospital accreditation; commission research on healthcare quality; and develop a strategic plan to shape the STC sector so that it is more efficient and effective.

- The aims of greater strategic purchasing of STC (and PHC facilities and services) should include the promotion of a more effective multi-disciplinary and holistic model of care involving allied health professionals and community care providers. The organisation of hospitals (and PHC facilities and services) into regional groupings would also form the basis for improving the integration of STC with PHC services and NGO services to assist with the shift of care from hospitals to the primary level and community.

- There was also consensus that shifting care out of hospitals, strengthening linkages to the primary care and community levels, and improving quality of care would require the implementation of an electronic health record system that would allow the patients' health information to be transferred seamlessly from hospitals to primary care, as well as a well-designed human resource plan to develop new skills and competencies. It was also noted that for the hospital sector to function effectively and efficiently, the population's health literacy would need to be improved.

- The question of how the new strategic purchasing agency would organise payments and contracts with providers was only briefly described. There was consensus that fee-for-service (FFS) payment mechanisms should be phased out. Where public and private hospitals compete for public funding, contracts and payments should be based on clear, transparent, and fair criteria.

- The government would also need to define the public's entitlements to STC and determine whether and how a co-payment system should be implemented. It was recommended that particular attention be paid to entitlements that would protect vulnerable households from catastrophic health expenditure.[9] It was also suggested that co-payments be used to discourage patients from consulting specialists directly instead of being referred by GPs.

Other discussion items

A number of other STC issues were discussed, but there was not enough time to formulate clear recommendations of ways forward as follows:

- Private practice in public facilities and private practice public sector employees was discussed as an issue that can impact the efficiency, equity, and quality of public hospitals. It was noted that income generated from private services in teaching hospitals like the University Malaya Medical Centre could be used to help fund research and subsidise public services. There was also a common view that public doctors should only practise privately in their own time and outside of public facilities.

- The need for more effective regulation of private voluntary health insurance (PVHI) was also discussed as it shapes how healthcare is practised in private hospitals and can have an effect on the patient load of public hospitals through the 'dumping' of patients by private hospitals onto the public sector when patients exceed their insurance coverage. The current governing body of PVHI is the Central Bank, which is mainly concerned with the financial sustainability of the insurers rather than the scope of benefit packages.

- It was recognised that the Health Tourism industry – delivered mainly by for-profit hospitals – needed to be self-sustaining and better regulated. Some of the concerns were that the government-funded promotion of health tourism did not provide enough benefit to the taxpayer and had negative impacts on the STC sector more broadly.

Success factors

It was noted that such an agenda of change will require strong political will and leadership, public and professional support, trust between different interest groups, and transparency, data and information.

[9] To prevent catastrophic health expenditure the benefit package would need to cover conditions such as chronic renal failure, acute MI, heart failure, stroke, chronic mental illness and cerebral palsy.

Human Resources for Health

Scope of discussion

Human resources for health (HRH) include doctors, dentists, pharmacists, nurses, and the wide variety of categories known as allied health personnel, including, for example, assistant medical officers, food technologists, physiotherapists, nutritionists, health education officers, environmental health officers, and several others.

Their training is specified, monitored, and approved by the Malaysian Qualifications Agency. Legislation requires them to be licenced to practise and governs the safety of services provided by them. Additionally, there are practitioners of Traditional and Complementary Medicine (TCM). Currently, initiatives are in progress to regulate their training and subsequent practice.

The focus of the round table discussion was on governance and financing options to remove existing constraints, and prepare HRH for future challenges related to:

- HR Production – quantity, categories, and quality
- HR Governance – improving equitable access to appropriate competencies, professional development, sustaining quality, and nurturing leadership
- Managing public expectations
- Broadening the talent pipeline

Background

The numbers, distribution, and competence of HRH are crucial for the quality and effectiveness of the health system. The rapid development of medical care in recent decades has been partnered by the rapid expansion of categories of HRH, with higher, more focused competencies.

Digitalisation will further change the roles and competencies required of HR. The effectiveness of health care is increasingly dependent on the health care team concept, with individual HRH collaborating inter-professionally with the patient at the centre of their actions.

Our number of HRH in relation to population size remains below that of countries with comparable GDP and countries with higher economic status, such as those in the OECD, UK, USA, and Australia (Figures 1 and 2).

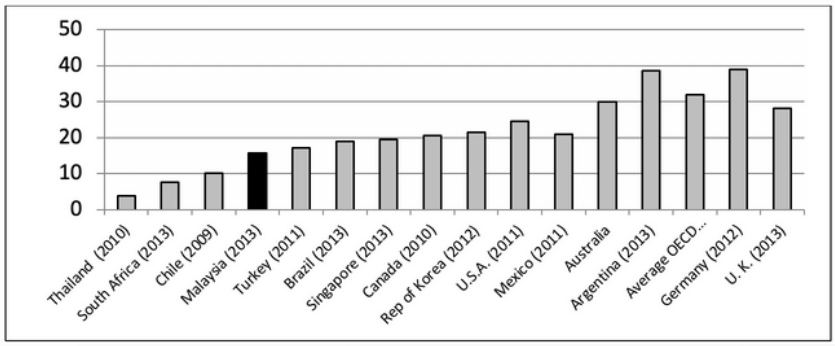

Figure 1: Doctors per 10,000 population

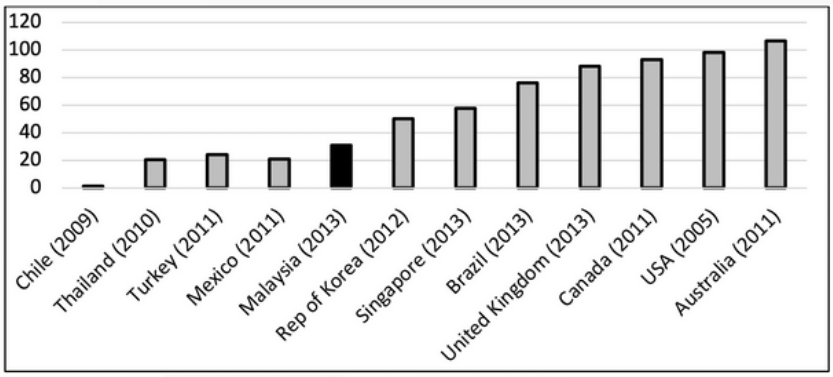

Figure 2: Nursing and Midwifery personnel per 10,000 population

Malaysia's HRH has a long reputation of making sterling contributions to the development of Malaysia. Recently, they provided yeoman service in controlling the COVID-19 pandemic.

A special feature of HRH arises from the lengthy training periods required to produce adequate competence and quality. Thus, there is a significant time-lag between decisions related to intake and quality of training programmes and their impact on the nation's healthcare. HR production systems need to anticipate and be geared towards future needs. Serious cracks in our HRH system have created recurrent crises with a negative impact on healthcare.

Imbalance between production of HRH and the utilisation capacity of our health system has resulted in delays in employment and career progression accompanied by public outcries; a decline in quality and competence of new entrants; emotional and financial stress on the entrants as well as their supervisory staff, who are thereby distracted from their primary role of patient care. Basic training of key categories of HRH is largely funded by the public sector and parents, and post-basic and postgraduate training is funded largely by the public sector. Yet private hospitals, which benefit from the services of skilled and experienced staff, pay little or nothing towards their training costs.

The health workforce needs to modernise to meet current and future challenges such as:

- reflecting the need to move care from expensive hospital settings to clinic and community settings;
- effectively using appropriate approaches to support healthier behaviour in the communities;
- using newer digital technology to support healthcare.

A mechanism is needed to synchronise the quantity, variety, and competencies of HRH with the current and future needs of the health system.

The governance of HRH has several strong features. However, there are gaps that adversely affect the quality and morale of the workforce and limit people's equitable access to healthcare. Outdated professional development pathways for doctors, dentists, pharmacists, and nurses create wasteful duplication, frustration, and loss of talent and morale. Rigid civil service rules and opaque systems negatively impact the nurturing and retention of higher and newer skills and competencies. This constrains the ability to respond sensitively and effectively to emerging needs, thereby limiting the agility of the system.

Key recommendations

There was a great deal of consensus on the major recommendations. It was agreed that the introduction of changes would need to be phased, with 'low hanging fruits' addressed in the immediate future while relevant legislative and administrative changes are put in place for the medium-term strategies. Recommendations include:

HR Production (involving the Ministries of Higher Education and Health)

- Establish a high-level multi-stakeholder HRH Board (public/private, Higher Education, Health, Defence, Professional bodies etc.) chaired by a senior Minister or Prime Minister with the responsibility and authority to synchronise HRH production with utilisation across the Health and Education and related sectors (public and private) and monitor the implementation of relevant policies. This Board should be supported by a dedicated secretariat responsible for collecting and analysing timely data (information) from across both sectors and providing timely future scenarios to support decision making.

- Manage public and political expectations and career demands by providing strategic leadership for adjusting benefits packages and career pathways to attract and retain the HRH categories that are required for the future health system.

- Rationalise the financing of HRH production so that private healthcare providers take responsibility for the education of the HRH they use. Phased introduction of various modalities was suggested, such as mandating private sector healthcare providers (and potentially future corporatised entities) to contribute significant financial inputs for the basic (pre-employment) and post basic and postgraduate training of their staff in universities and training institutions. Supportive measures could include: i) using a consortium of banks to manage the funds for training; and ii) requiring the payment of 'poaching' funds (that are significantly higher than 'bond repayment') when the private sector recruits experienced or highly skilled staff from public sector agencies.

- Improve the quality of HRH production through several measures to be implemented within the short term, including raising the academic requirements and the introduction of aptitude tests for entry into courses; criteria and a system for evaluating accreditors of training institutions; consolidating and strengthening existing institutions; reviewing, strengthening, and enforcing policies; reestablishment of new institutions; and implementing professional licencing examinations for all graduates from local and foreign training institutions.

- Replace Malaysia's outmoded house officer training with a seamless continuum of postgraduate training to accommodate early streaming and flexible training durations to meet the requirements of different specialties, while sustaining parity of benefits between specialities. Building upon the National Postgraduate Medical Curriculum project, establish institutional mechanisms for review, monitoring, and transparent governance mechanisms for postgraduate training.

HR Governance

- Improve access to and utilisation of available competencies of HRH by modification of rules and regulations to support task shifting and address the underutilisation, particularly in underserved remote areas, for example by:

  a) Empowering underutilised existing HRH such as community pharmacists to detect NCDs and manage their medication, provide immunisations, and improve health literacy in the community.
  b) Moving care from institutions and clinics to the community through trained teams of community-level workers, for example, community nurses with basic nursing skills, counsellors for mental health, transdisciplinary support for disabilities and the elderly, and specialised mobile teams for rapid response to deal with more severe problems.

- Corporatisation of facilities and services to enable revampingof personnel management rules for HRH to improve morale, motivation, and retention of skills through:

  a) Recognition of the needs of an increasingly feminised workforce (such as job-sharing, part-time work etc.).
  b) Implementing competitive, transparent merit-based systems for employment and postings.
  c) Converting all posts below specialist level to renewable fixed-term contracts, and synchronising the contracts to the duration of their chosen field of speciality training, and mobilising private sector specialists in postgraduate training programmes.
  d) Providing promotional posts within specialities.

- Broaden the talent pipeline to meet the challenges of the future through appropriate education and career pathways for priority groups, such as:

  a) Behavioural scientists with the competence to develop and support health behaviour change at strategic and grassroots levels.
  b) Data scientists and data security experts.
  c) Experts in the use of artificial intelligence (AI) tools with predictive capabilities to support, for example, (i) individuals to achieve their health potential, (ii) health care management and (iii) education of health professionals. Development of these categories would require parallel development of guidelines, regulations, and laws related to the use of AI in health care, especially regarding data integrity, security, and confidentiality.

Other suggestions

Systematic reviews to identify and address existing gaps in the training or availability of critical competencies (these would be 'low hanging fruits' that would yield rapid results). Examples include: emphasising the health component for health-related professionals, such as Safety and Health Officers, Prison health officers; and better enforcement of health and safety regulations in public and private institutions.

Whole-of-Society Approach to Health

Background

There are many reasons why a 'whole-of-society approach' and shared responsibilities for health across ministries are needed. Social, economic, and environmental determinants—through their impact on diets and nutrition, air quality, hygiene and sanitation, housing, and working conditions—have a greater influence over population health status than the functioning of the health system.

Threats to health that require multi-sectoral action include:

- Global warming and climate change
- Widening social and economic disparities
- Consumption of unhealthy goods
- Rising levels of stress, anxiety, and mental ill health

Health and development have bi-directional impacts and articulating this effectively is critical to securing buy-in for health from "non-health" actors. For example, appropriate aged-care options can relieve pressure on healthcare systems stemming from ageing populations with high rates of non-communicable diseases (NCDs); simultaneously, reducing the incidence of chronic disease among the elderly expands care options and reduces the burden on aged-care systems.

Therefore, it is important for Ministries of Health to be able to convey the message of shared responsibility for health, shape and influence the policies and interventions of other ministries and sectors, and ultimately mainstream health in the whole of government.

Key message

The MoH needs to be able to effectively advocate for a whole-of-government and whole-of-society approach to health and encourage other ministries to promote health and prevent disease.

Recommendations

- The White Paper should clearly signal the importance of a whole-of-society approach to health and sustainable development. In doing so, the White Paper could summarise the evidence showing how investments in health and healthcare can contribute to economic development and national security. This multi-sectoral focus should take a broad view of health and wellbeing so that each sector clearly bears responsibility for development decisions that impact health and the consequent benefits or costs to the economy and national security.

For example, climate change threatens health through many pathways: directly through increased frequency and intensity of climate disasters and the emergence of new and novel diseases; and indirectly by threatening food production and water supply; an increase in forced migration; and threats to healthcare systems. Preventing and mitigating these risks requires a range of actions that help society mitigate and adapt to the threats posed by global warming. These could include the development of new economic models that are consistent with planetary boundaries and the need to achieve zero-carbon targets.

- Leveraging the evidence linking health and development, the White Paper could propose new statutory mechanisms (or strengthen existing ones) to build multi-sectoral buy-in and ownership from key actors for a comprehensive health agenda.

  For example, the Welsh "Well-being of Future Generations Act" requires all public bodies to consider the long-term impacts of their decisions and develop partnerships to prevent persistent problems, including poverty, health inequalities, and climate change. The Act integrates health with other key development outcomes to create a shared framework of goals, methods, and accountability across all public bodies.

- Complementing statutory mechanisms, the White Paper could also propose:

  a) Mechanisms and requirements for mandatory reporting across ministries and agencies on health-related indicators.
  b) Breaking down 'sectoral silos' by integrating (organisationally or functionally) the multiple ministries with responsibility for health, welfare, and community development.

- To strengthen the MoH's ability to catalyse a 'health in all policies' approach, the White Paper could call for the establishment of a dedicated liaison unit to oversee cross-sector engagement as well as an internal policy unit with multi-sectoral competencies. Both would require personnel from non-medical and even non-health backgrounds.

  The internal policy unit would have two major functions: i) identification and prioritisation of issues and drivers beyond the health sector that impact health; and ii) generating evidence to make the development case for investments and initiatives in other sectors that advance health and wellbeing.

  Drawing on lessons from successful "gender mainstreaming" efforts, the liaison unit would need strong communication, advocacy, and partnership-building capacities. Securing partnerships with civil society organisations and shifting public mindsets will be as important as direct engagement with other ministries in securing a base to influence and enable change. In-depth understanding of the key performance indicators and other drivers of policy and activity in other ministries and sectors would be crucial to finding ways to advance health.

- To enable more effective multi-sectoral cooperation and coordination, the White Paper could call for greater standardisation and harmonisation of information systems across different sectors, as well as improved data sharing protocols. This would:

  a) enable evidence-based investment in policies and programmes that advance health, both within and beyond MOH.
  b) enable disaggregated tracking of health issues and outcomes, based on spatial location, age, gender, disabilities, and other risk factors.

Appendix 1

Programme for Experts Roundtable on MoH White Paper

UNITED NATIONS UNIVERSITY
UNU-IIGH
International Institute for Global Health

UNIVERSITY OF MALAYA

EXPERTS MEETING

Health Systems Roundtable for Ministry of Health White Paper

2 July 2022, 9:00 am - 5:30 pm
Faculty of Medicine, Universiti Malaya

PROGRAMME

• 8:30 am	Breakfast and Registration	Centrepoint	
• 9:00 am	Welcome	**Prof Dr April Camilla Roslani** Dean, Faculty of Medicine, UM	Faculty Room
	Introduction	**Prof Dr David McCoy** Research Lead, UNU-IIGH	
• 10:00 am	Concurrent Discussions		
	1) Healthcare Revenue Generation	Yap Wei Aun, Sharifa Ezat	Gallery
	2) Hospital Sector	Milton Lum, Ng Chiu Wan	SPM Conference Room
	3) Primary Care	David McCoy, Chee Yoke Ling	Faculty Room
• 12:00 nn	Lunch Break		
• 1:00 pm	Concurrent Discussions		
	4) Healthcare Finance Management	Sharifa Ezat, Yap Wei Aun	SPM Conference Room
	5) Beyond the Health Sector	David McCoy, David Tan	Faculty Room
	6) Human Resources	Indra Pathmanathan, Adeeba Kamarulzaman	CEPH Roundtable
	7) Medical Products & Devices	Chee Yoke Ling, Lim Chee Han	Gallery
• 3:00 pm	Break		
• 3:15 pm	Plenary Feedback and Presentation	**Groups 1-3**	Faculty Room
• 3:45 pm	Q&A and Discussion		
• 4:05 pm	Plenary Feedback and Presentation	**Groups 4-7**	Faculty Room
• 4:45 pm	Q&A and Discussion		
• 5:15 pm	Break		
• 5:30 pm	Wrap-up and Closing		

Appendix 2

List of Attendees

Participants

1	Dato' Dr Abdul Hamid Abdul Kadir	MAHSA University
2	Tan Sri Dato' Dr Abu Bakar Suleiman	Former MOH Director General; International Medical University
3	Prof Datuk Dr Allan Mathews	Malaysian Pharmaceutical Society
4	Amrahi Buang	Malaysian Pharmaceutical Society
5	Prof Dr Andrew Kiyu	Universiti Malaysia Sarawak
6	Prof Dato' Dr Anuar Zaini Md Zain	Monash University Malaysia
7	Prof April Camilla Roslani	University of Malaya
8	Assoc Prof Dr Azimatun Noor Aizuddin	National University of Malaysia
9	Azrul Mohd Khalib	Galen Centre
10	Dr Balachandran S Krishnan	Malaysian Medical Association
11	Boo Su Lyn	Galen Centre
12	Dr Chan Chee Khoon	Citizen's Health Initiative
13	Dr Chang Chee Seong	Medipulse
14	Dato' Dr Ding Lay Ming	Former MOH State & Hospital Director
15	Edmund Lim	Co-Founder of WeCareJourney
16	Dr Haniza Khalid	United Nations Development Programme
17	Harpreet Kaur	Malaysian Pharmaceutical Society
18	Dr Hyzan Mohd Yusof	OSA Technology
19	Prof Dr Jomo Sundaram	Khazanah Research Institute
20	Assoc Prof Dr Kamaliah Mohamad Noh	Former MOH Deputy Director for Primary Health Care, Family Health Development Division
21	Karina Yong	Third World Network
22	Dr Kawselyah Juval	Ministry of Health
23	Datuk Dr Kuljit Singh	Association of Private Hospitals Malaysia
24	Lim Kai Shen	Former Harvard Malaysia Health Systems Research Team Member
25	Dr Lim Kuan Joo	Former MOH State & Hospital Director
26	Dr Lim Shiang Cheng	RTI International
27	Dr Lim Teck Onn	Former MOH Clinical Research Centre Director; Clinique Healthy Malaysia

28	Dr Mark Cheong Wing Loong	Monash University Malaysia
29	Dr Mary Cardosa	Former President of the Malaysian Medical Association
30	Dr Muhammed Anis Abd Wahab	Ministry of Health
31	Dato Dr Narimah Awin	Former MOH Director of Family Health Development Division; Former Chairman of National Population and Family Development Board
32	Dr Rachel Koshy	Ministry of Health
33	Dr Rima Marhayu bt Abdul Rashid	Ministry of Health
34	Prof Dr Roslina Abdul Manap	Academy of Medicine Malaysia
35	Prof Dr Rosmawati Mohamed	Academy of Medicine Malaysia
36	Assoc Prof To' Puan Dr Safurah Ja'afaar	International Medical University
37	Datin Dr Sheamini Sivasampu	Institute for Clinical Research Malaysia
38	Datuk Dr Teoh Siang Chin	Malaysian Medical Association
39	Dr Tharani Loganathan	University of Malaya
40	Dr Thirunavukarasu Rajoo	Malaysian Medical Association
41	Prof Dr Thomas Paraidathathu	Taylor's University
42	Prof Thong Meow Keong	University Malaya Medical Centre
43	Prof Dr Victor Hoe Chee Wai Abdullah	University of Malaya
44	Dato' Dr Zaki Morad Mohamed Zaher	National Kidney Foundation; KPJ Hospital

Moderators

1	Dato' Prof Dr Adeeba Kamaruddin	University of Malaya
2	Chee Yoke Ling	Third World Network
3	Prof Dr David McCoy	UNU-IIGH
4	Dr David Tan	United Nations Development Programme
5	Dr Indra Pathmanathan	UNU-IIGH
6	Dr Lim Chee Han	Third World Network
7	Dr Milton Lum Siew Wah	Former President MMA
8	Prof Dr Ng Chiu Wan	University of Malaya
9	Prof Dr Sharifah Ezzat Wan Puteh	National University of Malaysia
10	Dr Yap Wei Aun	Former Harvard Malaysia Health Systems Research Team Member; Quanticlear Solutions

Observers

1	Dinash Aravind a/l Radakrishnan	Ministry of Health
2	Dr Feisul Idzwan Mustapha	Ministry of Health
3	Dr Mariana Mohd Yusoff	Ministry of Health
4	Dr Muhammad Asmi Syabil	Ministry of Health
5	Dr Muhammad Yazid Sahak	Ministry of Health
6	Nelleita Omar	Ministry of Health
7	Stefan Nachuk	Bill and Melinda Gates Foundation
8	Dr Taketo Tanaka	World Health Organisation
9	Dr Uma Ponnudurai	Ministry of Health
10	Dr Veronica Lugah	Ministry of Health

Secretrariat

1	Dr Ainol Haniza Kherul Anuwar	University of Malaya
2	Dr Ang Swee Hung	University of Malaya
3	Dr Diane Chong Woei Quan	University of Malaya
4	Dr Faeiz Syezri Adzmin Jaaffar	National University of Malaysia
5	Dr Hakimah Yusop	National University of Malaysia
6	Dr Kalaivane Kannadasan	University of Malaya
7	Dr Lye Chuan Way	University of Malaya
8	Dr Malindawati Mohd Fadzil	National University of Malaysia
9	Dr Ng Rui Jie	University of Malaya
10	Dr Syuhada Hamzah	National University of Malaysia
11	Dr Ting Teck Pei	University of Malaya
12	Dr Vivek Jason Jayaraj	University of Malaya
13	Shangeetha Thirumayni	Third World Network
14	Dr Kwan Soo Chen	UNU-IIGH
15	Dr Elaine Tan Su Yin	UNU-IIGH
16	Dr Chitra Rani Yogarajah	UNU-IIGH
17	Tengku Nadiahtul Zahraa	UNU-IIGH