## ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

**Malaysian healthcare system is dual-tiered; it is divided into a government-led and funded public sector, and a flourishing private sector leading to a dichotomous yet synergistic model. Although in terms of facilities and institutions, the private sector comprises more than half of the service, the majority of the population (more than 65%) is catered by the public services.**

**The public health services are delivered by the government via the Ministry of Health. Structurally, the Ministry of Health is headed by the politically appointed Minister of Health, who along with other upper managerial posts, are responsible for policy-making and direction setting. The operational aspect of policy implementation on the other hand, is led by the director-general of health, and this is further organised into different divisions; Of these, the two biggest from the medical point of view is the Medical Division and the Family Health Development Division. While the medical division is mainly in charge of the secondary and tertiary hospital care, the Family Health Development Division, where I was primarily attached to, focuses on public health and primary care.**

**The Family Health Development Division is further divided into two main branches: the Family Health branch, and the Primary Care branch. The Primary Care branch concerns the provision and maintenance of primary healthcare facilities and infrastructure, or in essence, the 'hardware' of the system, while the Family Health branch covers the 'software' of it, that is, the programmes concerning different patient population, including but not limited to Maternal and Child health, adolescent, the elderly, the disabled and the school children.**

**This structure is in many ways, similar to the UK healthcare system where the whole system is overseen by the ministerial Department of Health (DoH). However the executive body responsible for the operation, the National Health Services (NHS) is to a great extent, autonomous and separate from the department, unlike in Malaysia. Similarly, both systems are funded by the taxpayers, and the resources flow from the central federal level to the regional centres or states, leading to free healthcare at the point of use (or in Malaysia's case, healthcare at a nominal fee, as patients are charged RM1 for registration fee).**

**Throughout the first week of the electives, I was attached to the different units within the headquarter itself, and so managed to get some exposure on current developments and the direction Malaysian Healthcare is heading towards. I also managed to gain some understanding on how new policies are discussed and made, how old policies are reviewed, and how these are transmitted to the regional level to be implemented, how they are facilitated, and how feedback from below are gathered to measure the policies' success. To put it roughly, the process of policy-making initially**

**begins with either instruction from above (ie: the Ministry of Health), or in response to changes in needs and demands following reviews from data analysis from the ground. Then, a series of discussion follows involving the top tier management. When a new policy is passed, it has to be followed with development of guidelines and standards to facilitate implementation at the state and district level. Feedback is collected by means of return forms usually, both electronically and by paper.**

**I was also attached to the State Health Office in the Federal Territory of Kuala Lumpur, the capital of Malaysia, and the District Health Office in the rural district of Baling, in the state of Kedah in the second and third weeks respectively, giving me an opportunity to see how the policies are implemented at the operational level, and subsequently appreciate how the different urban versus rural settings influence how these are done.**

**At the regional level, provision of primary care services is coordinated by the state and district health offices. These services are centred around a central health clinic, which is led by a Family Medicine Specialist or a Medical Officer in Charge and caters to a population of around 40000 people. These health clinics are surrounded by smaller Mother and Child Health Clinics (led by a medical officer) and in more rural and secluded areas, rural clinics (led by a community nurse), which provide more basic services especially pertaining to maternal and child care, deal with more basic complaints, and also cater to a smaller number of population (around 5000 people catered by each rural clinic). This new structure is a departure from the previous 3-tier-structure, which includes a midwife clinic and a subhealth centre in addition to a main health centre. This previous system reflects historical emphasis, which is limited to the care of mothers and children, and focuses more on curative services. This upgrade to the new system not only improves accessibility and coverage, but also expands services to cover different aspects of health. This includes a shift of focus to a more holistic healthcare service, which is embodied by the acronym 'WISE', which stands for Wellness, Illness, Services and Emergency.**

**The 'wellness' aspect has gained a lot of attention in the Malaysian Healthcare System over the past decade. Through various new inititatives, the system is putting a lot more emphasis on preventive and promotional health. Among these are the rebranding the title of Medical Officer working in the community to Medical and Health Officer (MHO), effectively reflecting and expanding their roles in the community to ensure the maintenance and promotion of 'wellness' in the community. To this end, another initiative that is gradually being introduced is the Family Doctor Concept (FDC), whereby an MHO in the community is assigned to care for a population in a designated area, maximizing coverage and ensuring continuity-of-care. This is akin to the General Practice system in the UK.**

**Apart from that, the ministry also seeks to improve the community health by fostering engagement and involvement from the community itself. For example, for each health clinics, there is an advisory panel (Panel Penasihat) that involves healthcare workers from the clinic, as well as various members of the public, which are appointed by the clinic. These advisory panels receive a fixed amount of fund annually to carry out health promotion-related projects, like campaigns and health screening**

**targeting specific sections of the community that are not normally captured by the healthcare system like the elderly, and teenagers. This helps the health clinics to achieve targets set by the health offices. Other initiatives also include Komuniti Sihat, Perkasa Negara (KOSPEN) or 'Health Community, Empowering the Nation' programme, which recruits volunteers from the local members of the society. These volunteers will be educated, trained and equipped with basic equipments to conduct very basic health checks like taking blood pressure, and capillary blood glucose test. They will then go to the community and sometimes even from home to home in the designated area to conduct health screening and promotion. This kind of involvement helps to increase health awareness amongst the society, and also boosts uptake of medical advice in the community. Another important programme aimed at school students is Kelab Doktor Muda or the 'Young Doctors Club', an extracurricular activity introduced as early as the late 1990s. Much like school prefects and librarians, students joining the club will be appointed young doctors, and they will act as health advocates amongst their peers and organize health promotion activities at school. As they will gain extra credits for their involvement, students will be motivated to actively take part.**

**Another important aspect is the coverage of health services, especially in rural and secluded areas, in which some are not even accessible by conventional transport. One of the important changes in paradigm to achieve this is 'to go and proactively seek the patients, instead of waiting for the patients to come to the doctors'. This leads to the introduction of programmes like community outreach services, led by the medical assistants where teams of healthcare professionals based in the health offices go out to the secluded part of the community to organize health checks and deal with basic complaints. Medical and Health Officers, and the community nurses also carry out home visits. To improve access to very remote areas, there are mobile clinics that include vans and four-wheel drives fully equipped with medical facilities. There are also riverboat clinics and air clinics. In the urban areas on the other hand, problems with accessibility stem from long waiting queues and overcrowding in the main health clinics. Therefore, one of the initiatives introduced by the government in 2010 is the 1Malaysia Clinics, mainly run by the medical assistants and are equipped to deal with basic medical complaints and provide basic health services, while freeing some of the demands in the health clinics.**

**Apart from the 'Wellness' aspect, other services offered in the primary care and delivered by the health clinics include 'Illness' – that is, curative medical services and referral to secondary and tertiary centres if necessary and 'Services' which include auxiliary services delivered by Allied Health Practitioners such as the physiotherapists, occupational therapists, and others. In the health clinics, there are facilities available to support the delivery of these services that are regularly maintained and regulated by the health offices.**

**Apart from that, another important component is the delivery of emergency services, which are considered one of basic necessities in a comprehensive healthcare system. The emergency services in Malaysia can be reached via a single contact point by dialing 999, and this is then coordinated with the local health offices or hospitals where patients will be triaged to either the emergency department in hospitals or the health clinics. This is quite different than the UK where emergency services are referred straight to the hospitals. In Malaysia, there are ambulances provided in the**

**primary care settings. The health clinics are also well equipped to deal with common emergency situations like asthma attacks.**

**In general, I found that the public health in Malaysia has a great vision in improving primary care by increasing accessibility and coverage, and offering a very comprehensive and extensive range of services. Although Malaysian Healthcare system has traditionally put emphasis on Maternal and Children Health, different sections of the community are increasingly being considered and given more focus, for example, new units that focus solely on Men's health are being introduced following the findings that the male population has a higher rate of mortality due to lack of health awareness. There are also other units that cover all sections of population from the crib to the grave. Other important initiatives that encourage the involvement of the community, as well as the collaboration with other Ministries through the National Blue Ocean Strategy (NBOS) – an example would be the extensive collaboration with the Ministry of Women and Community Development in providing social care for patients – and creating a more inclusive environment for other healthcare staffs also put the healthcare system in a direction towards becoming a system worthy of that of the more developed nation. Modern technology is also increasingly being utilized in the system towards becoming more paperless.**

**However, barriers like lack of resources mean that these are often not fully and completely translated on the ground as envisioned by the top management. For example, a lot of the initiatives like the pink book provided to record and assess the development of children from birth to the age of 5 requires extensive training for the community nurses so they can provide adequate explanation to the parents. However, lack of funding and other resources may mean that these are not adequately done.**

**Apart from that, I also noticed some differences between the way healthcare is delivered in the urban area of Kuala Lumpur and the rural district of Baling. First of all, Kuala Lumpur is a designated federal territory and therefore, has a different administrative system compared to the other states. It is led by a mayor, as opposed to a chief minister in the other states, and the local authority Dewan Bandaraya Kuala Lumpur has a specific health division separate from the Ministry of Health. This means that there can be overlaps in terms of the services offered, and the areas covered for inspectorate actions. Although there have been efforts to coordinate these two services, as it is standing at the moment, a lot are still required.**

**There is also a difference in the health beliefs amongst the urban and rural population. The urban population tends to be more educated and have access to a wider range of information online, compared to their rural counterparts, whose beliefs tend to be colored by religion and culture. In the rural areas, traditional medicine is widespread and doctors have to take it into consideration when caring for patients. Even then, I noticed that most people in the rural Baling regards traditional medicine as complementary rather than alternative to modern medicine. Doctors are highly regarded and their advice are taken up more readily compared to their urban counterparts, whose I noticed,**

**due to access to online information and sentiment, are less trustful to doctors. Another thing that I noticed is that in the rural areas, access to clean water supply is still a major concern.**

**As a tropical country, infectious diseases remain to be quite endemic in Malaysia, with outbreaks happening every now and then. Diseases that remain to be major public health concerns are vector-borne diseases like Dengue fever and Chikugunya, and water and food-borne diseases like Thyphoid. Efforts to tackle these epidemics are mainly spearheaded by the health inspectorate unit, which has specific units to investigate cases of outbreaks, inspect food outlets and vendors, carry out vector control actions, and assess and supply clean water supply and sanitation in the rural areas especially. A good notification system is also in use to track cases and facilitate further actions.**

**However, as Malaysia is becoming a more developed nation, there has been a shift towards a more sedentary lifestyle, especially in the urban areas, leading to the rising prevalence of Non-Communicable Diseases like Obesity and Hypertension. This is very much similar to western countries like the UK. One initiative introduced by the Ministry of Health to combat these changes is Extended Primary Care Programme where efforts to screen the population for the Non-Communicable Diseases are intensified, and more preventative and promotional actions are being carried out.**

**Although the public health services in Malaysia are offered at a very nominal fee at the point of care, and are quite comprehensive and very much relatively advanced, with multiple secondary and tertiary centres offering advanced care situated in the centres of different regions, so that they are very accessible within each region, a great number of population, especially amongst the middle income populaiton still opt to go for more private health services, usually due to long queues and overcrowding in the public system. Consqeuently, the private health services and facilities flourish.**

**Statistically, there are about 220 private hospitals, and 6589 private primary care clinics compared to 138 hospitals and 2958 primary care facilities, including health clinics, community clinics and 1Malaysia clinics in the public sector. Even with this proportionally large private sector, the public sector still caters to the majority (about 80%) of the population, as the private sector is still not widely accessible, especially among lower income population, which still constitutes the majority of Malaysian population.**

**As there is a separate division in the Ministry of Health that deals with the regulation of private health services, I was not as exposed to the processes and issues involving the private healthcare services. However, from what I can gather, there are more initiatives being taken to bridge the two sectors, and utilise the ever expanding and flourishing private sector to improve the health of the community. For example, due to the huge number of private clinics in the community, there are talks about including these clinics in the Family Doctor Concept, to maximise coverage. However, this is still met with some resistance, as some private doctors feel that they would lose out significantly if this is to be introduced. There are also some talks about moving to a payment system based on insurance, so the community can gain equal access to the private facilities and the poorer covered by the Ministry of Welfare. This means spreading the cost of healthcare among the well-enough population, while maximising benefits gained from the private services. However, there are a lot of political and economical considerations that need to be taken, what with the current economic issues in the nation.**

**Throughout the three weeks, I had opportunity to be involved actively in various activities both at national and regional levels.**

**At the management level, I joined meetings, including Advisory Panel meetings at both the state and district levels, epidemiology meetings, and meetings with external stakeholders, for example teachers involved in school extracurricular activity 'Young Doctors Club'. I also joined an MBOR meeting with the State Health Office of the Federal Territory of Kuala Lumpur and Putrajaya to discuss the building of a new health facility in Cochrane. Through these meetings, I gained some experience and insight on how the processes and negotiations work.**

**On the ground, I also joined a couple of initiatives involving different healthcare teams. For example, I followed the health inspectorate team to performing inspection on food vendors in Medan Selera Jalan Duta and carrying out mosquito fogging in a community area in Kuala Lumpur and Baling respectively. I was also involved in investigating a recent chickenpox outbreak amongst school children.**

**Apart from that, I also joined the Kupang Health Clinic school team to school visits in Sekolah Kebangsaan Kampung Bandar. There, under the supervision of the medical officer, I conducted a head-to-toe health screening checks amongst Standard 1 primary school students. I also got to administer a few intramuscular vaccine injections. Another health initiative that I've been to is an outreach service to remote villages, in this case, Kampung Kuala Kedua in Siong. These projects are usually headed by a medical assistant, and so having a medical student on board is a good addition to the team. They asked me to conduct mini consultations with the villagers to address minor health complaints and promote health. It was an extremely useful experience, as I had to handle consultations in the local dialect, and there were a couple of local jargons that I struggled with. Trying to explain certain medical advice in their dialect also proved challenging, but the medical assistants and the other healthcare staff were of great help, and the experience was enriching.**

**Overall, I feel like the three weeks really gave me solid inputs in terms of both theories and hands on experience.**