Datuk Dr Noor Hisham Abdullah – Director General of Health, Malaysia



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Datuk Dr Noor Hisham Abdullah, director general of health at the Ministry of Health of Malaysia unveils the government's plan to bring healthcare back to the community, and create a culture based around a healthy lifestyle. Dr Hisham also discusses the future potential for digitalization within the Malaysian healthcare apparatus.

On 9th May this year, a new government administration took power. What has been the government's first priority for healthcare?

On 14th May we had a meeting with the new Prime Minister. The Prime Minister's mission is to consider how best we can improve healthcare provision in the country while avoiding corruption and increasing transparency. Secondly, we intend to continue to support the delivery of quality healthcare services to our population.

Universal health coverage has existed in Malaysia since independence, but the healthcare system in its current form is unsustainable. The Prime Minister has mentioned that contributions must be based on wealth, with the government subsidising the most vulnerable in our society. Furthermore, during a mid-term review, the Prime Minister remarked that some form of health insurance is worth considering bridging the gap between the public and private sectors, maximising resources across them.

What have been the initiatives taken to reform the healthcare system?

Our healthcare system is based on maternal child health. Our main focus has been to develop initiatives to address communicable diseases, and their recent re-emergence, for example, Ebola. However, in recent years we have observed a rising incidence of non-communicable diseases. The incidence of diabetes has increased from 6.6 percent to 17.5 percent of the population. Hypertension is now at around 30 percent, and obesity is increasing too with around 45 percent of the population being overweight. Consequently, our current systems are insufficient. Therefore, we have begun by enhancing primary care to empower the public to subscribe to a healthier lifestyle under the assertion that prevention is better than cure. We must concentrate on implementing adequate screening and better address the control of the conditions for those who have already been diagnosed. Regarding diabetes, half of those with the condition are undiagnosed. Amongst those diagnosed, 50 percent are poorly controlling the condition.

We are also engaged in creating self-help programmes based around community empowerment. We empower the community to care for themselves by designating an area in a village for exercise and labelling buildings as no smoking zones. We began with the parliament building, outlawing smoking inside. We hope that this will set an example and trickle down to the community. We undertake a lot of promotional campaigns against smoking and alcohol. To encourage healthy eating, we have created the concept of "*quarter, quarter, half*" which indicates that every meal should be composed of one quarter of protein, one quarter of carbohydrates and half of vegetables. We would like to see the mindset towards healthcare transformed, with the general public more inclined to exercise regularly, avoid cigarettes and alcohol, and eat healthily. To develop this cultural change, education must start early, from schooling age. We also endeavour to facilitate health screenings within the community, for example, blood pressure and blood sugar monitoring. Only after detecting irregularities will the patient require a referral to the clinic. We hope this engagement will create better condition management over time.

Public health centres are also overwhelmed by the numbers of patients coming in for treatment. What can be done to ensure that patients have a better access to health services?

Our clinics are already congested and are subject to a vicious cycle: as the quality increases, more patients visit the clinics, which in turn creates more congestion. We are investigating the possibility

to bring primary care back to the community and to patients' homes, for example reviving the concept of family doctors. Nurses have been undertaking this work in post-natal care ever since independence. Now, we are going to extend it further, for example, stroke patients, or those with wounds who could have them dressed at home rather than in the clinic. We believe that outcomes will be better if patients can avoid admission into the hospital.

We also realise that our clinics are not designed to handle non-communicable diseases. We have initiated a pilot project in 30 clinics where patients are followed by the same medical team every time they visit the hospital so that they become well acquainted. The initial results of this scheme have shown stronger patient engagement. We hope that this improved engagement will be translated into improved control.

Digitalization has become a key focus for the new administration. How is the will for a more digitalized service being achieved?

When contemplating ideas and innovation, we mean new technologies that will change the healthcare landscape in this country. The Ministry of Health is trying to provide a framework to ensure that this is possible. We have formed a multi-sector team to decide how best to achieve this.

In October, the Ministry of Health signed a Memorandum of Understanding (MoU) with Collaborative Research Engineering Science and Technology (CREST), who represent the medical industry. By involving them in the digitalization project, we can scale up ideas into commercialisation. We already have systems in place. For example, 148 of our hospitals offer courier and drive-through services to deliver prescriptions to patients' home. We can improve further by leveraging innovation and new devices. In fact, the doctor can carry with them 36 points of care testing to identify diseases such as HIV, Hepatitis C, Typhoid and Dengue fever. After a consultation, this information can be uploaded to the iCloud or other cloud platform and once a diagnosis has been made, the prescription will be completed electronically. We have to create an ecosystem for new software and devices and bring it to the patient's home.

Moreover, at the national level, every hospital has different software and systems, so our goal is to integrate all centres in one platform. Therefore, we are considering creating our own hospital information system, whose intellectual property will belong to the government, and to upscale this to cover the whole country.

Healthcare inflation is predicted to reach 17 percent this year. What have been your strategies to keep costs under control?

One way to lower costs is to optimise the resources we already have. Of 143 hospitals, only 55 have specialists in place, while the others are run by medical officers. To accommodate all patients, we have created hospital clusters, meaning that the lead state hospital will also bear responsibility for the district hospitals. Moreover, we are reconsidering the processes in place using Lean Healthcare. Some were designed 30 years ago and are now obsolete, so we need to redesign these procedures to make things leaner and to reduce inefficacies.

Secondly, we are taking some of the services out of the hospital. An example is the alternative birth centre (or low-risk birthing centre) that will allow normal childbirth to be made in adapted community centres instead of hospitals to lessen the burden on the latter. They are situated near hospitals so that patients can be taken there quickly in the case of complications.

The other element is to cut wastage. We are tackling unnecessary prescriptions, along with the purchasing of drugs that go on to expire before being used by having a system that can allocate the drugs to needed areas.

Finally, we look into collaborations with the private sector and NGOs. We have increased the cost-effectiveness and efficiency of minor surgeries, such as cataract surgery by partnering with an outside organisation. They have a theatre and conduct cataract operations daily. In a normal theatre, seven operations can take place per day, whereas the new facility can conduct 15.

How would you assess the collaboration with the industry?

When drugs are expensive, we partner with international organisations to conduct research, and to provide services and education. For example, Malaysia has almost half a million patients in Malaysia suffering from Hepatitis C. Through collaborative research, we reduced the cost of the hepatitis C medication from USD 800,000 to USD 300 for curative treatment for one patient.

The possibility of pooling procurement is also under consideration. By increasing the volume ordered at one time, we can decrease the cost per unit through economies of scale. The new government’s initial priority is pooling procurement with the public sector for military hospitals, the Ministry of Health, and the Ministry of Education, but we could also explore the pooling of

procurement with the private sector. This has been achieved in the past, in particular during the purchase of testing kits for dengue fever. Initially, the general practitioners were unwilling to use them as the cost was MYR 90 (USD 21). By pooling the orders of all 9000 clinics, we negotiated with the vendor to reduce the cost of the testing kit, cutting the price from to MYR 15 (USD 3.60).

How does the Ministry of Health seek to attract the best medical professionals?

This Ministry of Health is built on passion and dedication. Many of our doctors remain in the public sector not for the financial remuneration, but out of love for their profession. The private sector's pull factor is always there. What we must do is remove the push factors that force doctors to leave the public sector by improving services, training, and opportunities to conduct research.

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