Health Planning in the Context of National Development Planning, Malaysia

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Background

NATIONAL DEVELOPMENT PLANNING has been in existence in Malaysia for over 17 years. Even before the attainment of Independence, the then "Federation of Malaya" had launched its First 5-Year Development Plan in 1956 (First Malaya Plan). Malaya achieved its Independence in 1957 and embarked on the Second 5-Year Development Plan in 1961 (Second Malaya Plan). During 1963 the states of Sabah, Sarawak and Singapore joined Malaya in forming the new nation of Malaysia (Singapore subsequently left Malaysia to become an Independent Republic State). The new nation then embarked on its 3rd 5-Year National Development Plan (1966-1970) called the First Malaysia Plan. Presently the country is in the second year of the 4th 5-Year National Development Plan – the Second Malaysia Plan (1971-1975). Over these past 17 years, as a result of a very intensive effort conducted by Government to create "development consciousness" amongst the peoples of the country "National and Rural Development" and "Development Planning" have become a way of life in the country. This motivation for "Development Planning" has permeated through the whole fabric of government and society from the very top political decision makers down to the "Ketua Kampung" (village headman) and the members of the village development planning committees comprising representatives from the rural communities.

National Administrative Framework in Planning

At the national level the staff-work on national development planning is the responsibility of the Economic Planning Unit (E.P.U.) of the Prime Minister's Department. In this role, it provides the staff-work to the National Economic Council which is a Ministerial body under the Chairmanship of the Prime Minister himself. The EPU in addition serves as the secretariat to the National Development Planning Committee (NDPC) consisting of senior public officers responsible for the formulation of the Plan, its periodic review, and its implementation. The Estimates Sub-Committee of the NDPC is responsible for detailed appraisal and examination of the Development Estimates. These estimates provide the annual development expenditure phasing of the public sector component of the Plan. A Standards and Costs Sub-Committee of the NDPC is responsible for formulating and providing guidelines for project-designs and standards to ensure that maximum economies are achieved. Both these Sub-Committees are also serviced by the EPU.

To complement the work of the central planning agencies, "Planning and Research Units" have been established in major ministries and departments such as the Treasury, Bank Negara, the Public Works Department and the Ministries of Agriculture, Education, Health & Transport. These Planning and Research Units work in very close collaboration with the EPU in the formulation of their respective sectoral development plans.

Review of past plans

At the start of the formulation of the Second Malaysia Plan a review of the past achievements showed that Malaysia's development to date had been substantial. It was however noted that al-

though remarkable progress had been achieved in all fields of economic and social development, the increased and improved education, growing urbanization and expanding economic activity had all resulted in the creation of new ideas, the loosening of old ties, the questioning of traditional values, and the search for new sources of meaning and understanding, particularly among the youth of society. It was noted that these developments in turn had resulted in the emergence of a socially and politically volatile society. An urgent and permanent solution had to be found to this new set of problems and there was felt the need for the evolution of new values, and new concepts and policies of social and economic order. Economic policies and development had to be considered in their relationship to social development and to the overriding need for national unity in the context of a multi-racial society. There was an imperative need to incorporate policies and measures to eradicate poverty through raising income levels, generating new employment opportunities and to restructure the society to correct racial economic imbalance.

New Policies for the Second Malaysia Plan

The Second Malaysia Plan therefore had to be designed in a manner that would see the emergence of a new "socio-economic" policy geared to the task of creating a united, socially just, economically quitable and progressive nation. Under the new socio-economic policy "development" would have to be undertaken in such a manner, that in the process of growth and expansion, the changes that would occur would make the maximum contribution to the achievement of national unity. Some of the more important policy decisions arrived at, which the health sector had to take serious account of in its own planning included —

A. **Eradication of poverty**

- Increasing opportunities for inter-sectoral movements from low productivity to higher productivity areas in new land development schemes ..... including the necessary organizational arrangements to facilitate movements into these modern sectors.
- Providing a wide range of free or subsidized social services (including Health and Medical Services) designed to raise the living standards of the low income groups.
- Greater job opportunities to be created especially for youths of all races.
- Steps to be taken to overcome the problems posed by extremely rapid population growth.

B. **Restructuring Society and Economic Imbalance**

- Modernization of rural life.
- Creation of a Malay commercial and industrial community.
- More equitable income distribution.
- Rapid growth of employment opportunities among the disadvantaged groups.
- Development of new regional economic growth areas.
- Provision of Schools, Libraries, Health facilities etc. ..... of as good a quality in the rural areas as in the urban areas ..... to make life richer and more rewarding for those who live in rural areas.
- Establishment of new manufacturing activities in rural areas now almost exclusively devoted to agriculture and mining.

It would appear that there was implecit in the Second Malaysia Plan a trend for economic planning for social goals, with economic development as a means rather than an end. In view of this it became important to ensure that the "Health Sector Development" was so planned as to make maximum contribution during the plan-period in consonance with the philosphy of government.

Health Planning

In the context of the above overall aims and objective enumerated by Government, and the subsequent statement of policies for the period of the Second Malaysia Plan, it became necessary for the Health Sector development planners to critically appraise the following:—

(i) the adequacy of the Rural Health Services infrastructure, and also its distribution pattern amongst the various states throughout the country to ensure that those regions/areas which were inadequately covered were given the highest priority;

(ii) the distribution pattern of medical-care services amongst the different states (Bed/population ratio, doctor/population ratio etc.) to determine areas which had lagged behind and therefore needed higher priority consideration;

(iii) the "level" of medical care being provided in the different states (including the

specialist services) to ensure a more equitable distribution of the quality of medical care;

(iv) the total health manpower resources required in order to determine the rate of increase required in the training capacity for medical, dental and paramedical personnel. This was to be given a very high priority in view of government's aim to provide a greater quantum (wide range) of free or subsidized social services (including health and medical services) designed to raise the living standard of the lower income groups;

(v) the anticipated additional requirements for health services in new land development schemes, and in the proposed new industrial and new regional economic growth areas;

(vi) the likely health (mental, physical & social) hazards that might arise out of rapid urbanization, industrialization and population migration with a view of proposing early and adequate prophylactic and preventive health measures;

(vii) the role that the health sector could contribute to overcome the problems posed by extremely rapid population growth;

(viii) the effect of certain major health problems that may retard the rate of development and economic growth (malaria, malnutrition, accidents and disability affecting production-workers etc.) in order to formulate adequate national programmes to reduce these problems to the minimum; and

(ix) how much emphasis had to be placed on preventive aspects of the health delivery system.

Findings and Conclusions

Studies carried out as a part of the plan formulation process revealed that:—

(i) there did exist disparities in the distribution of the rural health facilities throughout the country;

(ii) the bed/population radio, doctor/population ratio showed inequitability of distribution (including specialist facilities), with the less developed states in fact getting a poorer share of the cake;

(iii) a growing suburban population surrounding the major cities of the country were not adequately provided with health services;

(iv) there was a shortage of professional technical and paramedical health manpower to man even the existing health facilities adequately;

(v) the assumption that the district and general hospitals were catering solely for the urban population was incorrect, as over 30% of the facilities provided at both outpatient and inpatient level at these hospitals was in fact being utilized by the rural population;

(vi) the family planning clinics started at the hospitals and some clinics were proving effective (increasing numbers of new acceptors) and that this might be expanded usefully into the rural health service delivery system; and

(vii) the quality of care (availability of laboratory, X'ray, Operation theatre, accident and emergency services) was inequitably distributed throughout the country.

As a result of the above findings major policy decisions on the following lines were taken—

(i) the highest priority be given to redressing the inequitable distribution of the health delivery system (Rural health services, patient-care services including district and general hospital beds and medical and paramedical personnel);

(ii) that the training programme for all categories of key medical and paramedical staff be stepped-up considerably as a matter of urgency;

(iii) the quality or level of care be stepped-up in all hospitals especially the district hospitals in areas covering large catchment areas of rural population by the provision of adequate diagnostic and treatment facilities and the posting of specialists to these hospitals;

(iv) the extension of the coverage of the rural health services into the more remote rural areas, by increasing the mobility of the staff posted to the rural health units;

(v) family planning be functionally integrated into the rural health service;

(vi) the national programme like malaria eradication, nutritional improvement, environmental sanitation etc. ..... be stepped-up as a matter of the highest priority to support the overall national economic development programmes;

(vii) special emphasis be given to the development of new health delivery systems to support major economic activities of government such as new land development schemes and new industrial and regional economic growth areas; and

(viii) wherever possible the growth and expansion of the health delivery system be designed to be labour-intensive to support the overall aim of new job creation.

Plan formulation process

Based on the findings outlined above, directives were sent out to the various State Heads of Medical Services explaining the overall socio-economic goals set out by Government, and the broad policies that the Ministry of Health had set for the health sector plan to support the overall aims and objectives of Government. The State Heads of Medical Services were then requested to critically appraise the health delivery system within their state in greater detail and to come up with firm proposals — on a "project to project" basis — based on the broad policies laid down by the Ministry of Health. Each project had to be described in detail as follows:—

(i) Background and problem statement.

(ii) Project proposal — description of project.

(iii) Cost estimates — capital expenditure

— recurrent expenditure.

(iv) Manpower requirements.

(v) Benefits and justification.

(vi) Schedule of implementation.

(vii) Statement of priorities.

All these individual project proposals were then submitted to the Division of Planning and Research with copies to the respective Divisional Heads within the Ministry (Hospital Division, Dental Division and Health Division). The Division of Planning and Research then called a series of meetings with the individual State Heads of Medical Services and critically examined each project proposal wherever considered necessary. This was then followed by a series of meetings at the Ministry level with the Heads of Divisions (under the chairmanship of the Director of Planning and Research) where the various project proposals which had been classified and aggregated under various activity heads were discussed and accepted, or suitably modified or rejected. The composite plan was then presented to the Minister of Health for final acceptance.

It will be noted that the above procedures—

(i) enabled the State Heads of Medical Services to develop a health plan at state level on the basis of broad policy decisions enunciated at the Ministry (national) level;

(ii) enabled State Heads of Medical Services to liaise with the State Governments (State Development Committees) prior to submission of project proposals;

(iii) enabled the Ministry to get a feed-up of proposals based on local needs;

(iv) enabled the heads of various Divisions in the Ministry to contribute to the plan formulation process; and

(v) ensured that the "central planning team" in the Ministry continuously acted as the coordinating agency throughout the entire planning process.

One of the very satisfying features of the up-down, down-up planning process, combined with the horizontal dialogue between the various Divisions of the Ministry was that it exposed a large number of senior and middle level management personnel to the planning process. Although the bulk of the staff-work had to be borne by the Division of Planning and Research, it was however greatly relieved of the detailed preparatory work required on an individual project by project basis.

The whole process of plan formulation lasted seven months from the time of the initial "call-circular" received from the Prime Minister's Department to the submission of the firm proposals to the Economic Planning Unit and the central agencies (Treasury, etc. .....)

Subsequent analysis revealed that the time constraint —

(i) did not enable the Health Sector to develop an in-depth analysis of the health situation as would have been desirable;

(ii) did not enable the "Division of Planning and Research" to initiate adequate consultation with the various "senior clinical consultants" in the Hospital service, and with the various "programme directors" in the public health service; and

(iii) precluded initiation of a dialogue with other peers in the health field (private medical sector, university etc. .....)

One of the major weaknesses identified in the planning process was the inadequacy of "data" in suitable form on which to make rational decision. While it was found that there was an abundance of raw data being collected at all levels within the health system, much of this was valueless for planning purposes in the form available. Another major area of weakness was that data on "operating cost" of services was only available as macro-aggregate at State level and it was virtually impossible to identify the efficiency of various health units (hospitals, health centres etc. .....) in relation to outputs.

Generally, it can be stated that the planning process was simplistic in nature, and did not include the sophisticated methodologies of the Planning, Programming Budgeting System (P.P.B.S.), cost benefit analysis, system analysis, P.E.R.T., etc.....

Greater emphasis was placed on the detailing out of the implementation schedule, the monitoring of progress, and the building in of check-mechanisms with early intervention by the Ministry to ensure success in implementation. When the health plan was approved by Government (with very slight modification to the original submission), each and every project was tabulated in great detail showing the size and scope of project, location of project, the estimated cost, and the year of implementation. Various milestones were clearly identified (land purchase, detailed design, tendering process, construction work, equipping, commissioning, etc.) and targets set for them. These were then sent to the various State Heads of Medical Services for implementation. The implementation section of the Division of Planning and Research was given the responsibility of monitoring all the projects individually at national level, through a "feed-up reporting system" from the ground. It was empowered to intervene whenever necessary to ensure that targets set out were met.

At the higher Government level, there is a "National Operations Room" where all Ministries have to maintain up-to-date charts on the progress of plan implementation. The Prime Minister himself personally chairs monthly meetings at the National Operations Room where all heads of Government departments and Ministries are present and where any one of the heads may be called upon to brief the meetings on the progress achieved by his department/ministry.

Evaluation:

Built in into the planning process is a "mid-term review" provision, where it is mandatory for every Ministry/Department to carry out an evaluation of progress in relation to the targets set at a point of time midway through the plan period.

Opportunity is also given for a critical appraisal of policies and derivative goals at sectoral level in relation to their contribution to the overall aims and objectives of Government; and to effect necessary changes of programmes for the second half of the plan period if considered necessary.

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