
ORIGINAL ARTICLE

THE MALAYSIAN HEALTH REFORM IN PRIMARY HEALTH CARE SERVICES

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ABSTRACT

Introduction : Family Health Development Division is one of the earliest divisions in Public Health Department, Ministry of Health Malaysia. The division has progressed each year with the extension and expansion of the scopes of services since the establishment of Maternal and Child Health Unit in 1956. The services currently include school children, adolescent, adult and elderly health and also known as life-course perspective: from womb to tomb.

Objectives : The objective is to elaborate and explain the reformation of primary health care services implemented in the past and present.

Methods : The methodology applied is compilation, data review and comparison from annual report, action plan report, articles, speeches, specialists and stake holder view.

Results : The focus of Primary Health Care Service is covering health promotion, disease prevention, early detection and treatment, acute disease care, disease limitation and rehabilitation, clinical support services and teleprimary care. The reformation is caused by factors such as globalization, modernization, growth of health market, emergence and re-emergence of diseases, and development of medical technology. Three health fields that have underwent and under going reformation are concept and wellness practise in primary healthcare, primary healthcare clinical support services development and primary healthcare informatics development. The outcome of these reformations is the increment of service quality and outstanding services for patients and health staffs.

Conclusion : Health reformation in primary healthcare is greatly needed to give excellent services for primary health care for today and future.

Keywords : Reform, Primary Health Care.

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INTRODUCTION

Primary Health Care in Malaysia

Family Health Development Division was established in public health services in Malaysia since 1956. It has progressed each year with the extension and expansion of the scopes of services. These developments do cover all its needed services; i.e. maternal and child health, health of school children, adolescents, adult and elderly which reflect to a life-course perspective: from womb to tomb. Other special services are mental health and rehabilitation services which also been started in order to meet the demand of the community for a comprehensive health care. These developments were also called health care reform which major policy changes took place. As an example is Nutritional Programme for maternal and children and Poverty Eradication Programme which resulting in improved the health status with reduction of malnutrition rate up to the whole community level. Rural Health services which has been started with small health centre and maternal clinics was replaced with the more spacious Community Clinics equipped with more complete clinical support service. The services that started with paramedics; nurses and medical assistants now have been upgraded to specialist care (Family Medicine Specialist) together with more clinical support service staffs. Maternal and Child Health Service scope has been broaden and expanded from promotive and preventive base to curative and rehabilitative services. In Sixth Malaysia Plan, the outpatient services have been parked taken care by Primary Health Care services under Family Health Development Division, Ministry of Health Malaysia.

As a result of these reformation processes, the landscape of primary health care service has been changed from rudimentary service to the more comprehensive service which caters for all in the community at the grass root level regardless whether in urban or rural areas.

Goals in Malaysian Primary Health Care

The role of Family Health Development Division is explained by its vision and mission, i.e. managing health service through planning, implementation, monitoring and evaluation activities regarding family health, nutrition and primary health care in Malaysia which towards building a healthy family that enjoys quality life for life and to produce a healthy family institution. In order to materialize the directions, Family Health Division had formed four sub-divisions which are responsible for the specific functions. First sub division is Family Health Division. This division is a responsible on

the maternal, prenatal and child health, school health service, adolescent health, women's health, elderly health and rehabilitation. Second sub division is Nutritional Division. Its responsibility is on nutritional corrective and promotional activities at all levels. Third sub division is Primary Health Care Division which responsible on operational policy, infrastructures, medical technology, and carrier development of health staff at the Primary Health Care facilities. The final sub division is Mental Health Care Division. It is newly developed with responsible on implementation of mental healthcare program¹.

Evolvement and Reforming of Malaysian Primary Healthcare

Primary Health Care is relatively a new division which formed in Sixth Malaysia Plan. Since 1996 with the initial focus of developing the service of Family Medicine Specialist, its function has been revised to cover not only family health but more comprehensive which is delivering primary care at the first point of contact to selected Ministry of Health service facilities. At the same time, efforts to see primary service provided by private sectors are taken care of, so that a comprehensive method which stresses on equity and equality is monitored by Ministry of Health. These are parallel with the Malaysian vision of health, i.e. to develop a nation of healthy individuals, families and communities, through a health system that is equitable, affordable, technologically appropriate, environmentally adaptable, consumer friendly, with emphasis of quality, innovation, health promotion, respect for human dignity, and which promotes individual responsibility and community participation towards enhanced quality of life. In addition to that, the mission of the Ministry of Health is to build partnerships for health to facilitate and support the people to attain fully their potential in health, to motivate them to appreciate health as a valuable asset and to ensure they are taking positive action to improve further and sustain their health status to enjoy a better quality of life¹.

As references, our health planning of policies and activities is always based on "8 Goals of Health Services, i.e., wellness focus, person focus, informed person, self help, care provided at home or close to home, seamless, continuous care, services tailored to individual or group need and effective, efficient and affordable services². Primary Health Care is the core of health service to the community which has 6 main focuses, i.e. producing a comprehensive service with the integration of programs from other sub-division, planning and managing the need and development of human resource, planning and supervising the

existence of infrastructures-buildings, equipments, clinical support services, information technology and communication, analyzing operational system and policy at Primary Health Care level, organizing the participation of private sectors and non governmental agencies at Primary Health Care level and managing a quality service through research, Quality Assurance, ISO 9000, and Health Technology Assessment. The new focus of Primary Health Care Service is more on 5 main level of primary care which is health promotion, disease prevention, early detection and treatment, acute disease care, disease limitation and rehabilitation. Focus is also on the clinical support services and teleprimary care.

Three-tier Rural Health Service

The service was operated since 1957. It was revised in 1973 due to development of the nation. Since then the rural service was upgraded into Two-tier health setting. Initially the main health centre is build to cater for 50,000 populations. There were 4 sub-health centres for 10,000 populations and another 20 midwife clinics for 2000 populations. A Medical and Health Officer (M & HO) is heading the Rural Health Unit (Unit Kesihatan Luar Bandar). The services provided were Out-patient Department (OPD), Maternal and Child Health (MCH), Environmental Sanitation and Dental. The same services were provided in sub-health centre except dental service. On the other hand the midwife clinics are run by midwife and deal only with maternity cases.

Two-tier Rural Health Service

Since 1973 the Three-tier Rural Health service was upgraded to Two-tier service which consist of Health Centres and Community Clinics where as formally Sub Health Centre is upgraded to Health Centre. Health Centres are build to cater for 15,000 to 20,000 populations where as Community Clinics are for 3,000 to 4,000 populations. Mean while the midwife clinic was upgraded to Community Clinic which provide both Maternal and Child Health and Out-Patient Department Services.

Healthcare Reformation: Overview of Healthcare Reformation in Other Countries

Health reformation occurs throughout the world. It is a part of globalization phenomenon. In the United Kingdom, there is a program that tried to reform the British National Health Service started in 2007³. As well as in United States, recently Medicare Prescription Drug Improvement and Modernization has been singed into the law. It includes a prescription drug plan for elderly and

disabled Americans³. In Germany, Netherlands and Swiss, the recent reformation in health are more about health insurance³. In Germany as example the citizen are appreciative to join the scheme but they are also given option to draw or opt out, whilst in Netherlands the threshold to opt out is lower. In Swiss, the recent reformation regarding health insurance is the private health insurance will use risk rated parameter such as age and sex.³ As a result of reformation, United State has developed a unique healthcare insurance setting³. They leave the free market to deliver most of the health services. United State will be an outlier when the health care expenditure per capita and GDP were graphed⁴. Specifically on health insurance, U.S. insurance markets were systematically implemented with appropriate safeguard, but it can cause more problems if it is not monitor systematically^{4,5}. These reflect that reformations need certain control and monitoring to produce best result.

Why Reformation Happened in Primary Health Care?

Health care reform means a major policy creation or changes in most of its part that regards and affect of the healthcare delivery. The change mostly due to factors such as globalisation, modernity and value changes, growth of market for health and emergence of new agent in health field⁶. The other factor is like broaden population as example increase aging population i.e. in Japan⁷. For further explanation, globalization which happened around us is beyond our control. It will affect us through our cognitive via spatial and temporal ways. As an example is the implementation of International Health Regulation especially in controlling the infectious diseases⁶. The other is like the tobacco control activities, which implies the inter-governmental agreement. Globalisation will provide opportunities for internationalising of local public health which happened during industrial revolution, i.e. International Health Regulation. Apart from that other example of globalisation effect on health reformation is the Alma Ata Declaration. The impacts were seen through the policy and planning changes throughout the world. It state that the strong reaffirm health is a state of a complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector⁸. In addition to that, the implementation of Ottawa Charter also is an example of the effect of

globalisation⁹. Ottawa Charter helps to maintain the basic health requirement such as peace, shelter, education, food, income, stable eco-system, sustainable resources, social justice and equity⁹. It affect the operational direction of healthcare in most of the countries especially the one who is WHO member.

The other factor that makes such changes (primary healthcare reform) is modernity and value mean of people that have been changed. Modernisation will increase focus on individual which result on individualisation and differentiation of individual health values. This will give consequences on increase consumer demand, diversity and flexibility of the health services. As an example is patient or client satisfaction program. Patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses. The main complaints centred on the availability of prescribed drugs and laboratory investigations¹⁰. This shows that how changed values will make changes in healthcare services. For the growth of markets for health and ill health means that not only has illness emerged as an industry but there has also emerged a wellness market combining Public Health policy and consumer policy. These also explain by consumers who have turned away from the strictures of traditional medicine to complementary and alternative health therapies. In term emerging new agent that can cause unpredicted to health, WHO has a great concern on it. As though it is still limited in few countries, extra steps have been taken into action to control the possible spreading potential. As an example is influenza pandemic preparedness, west fever preparedness, SARS. Etc. This new emergence agent also can arise from antibiotic resistance microbes¹¹. Once the resistances happened, medical practices and policies need reconsideration. Apart from that, the new finding of infectious causes that lead to cancer, arthritis and other chronic disease is also consider a new agent¹¹.

Malaysian Primary Healthcare Reformation

There are almost similar factors affect the Malaysian Primary Healthcare System, beside a major change via Alma Ata Declaration in 1978 which classified more towards globalisation, modernity and changes of value like in customer satisfaction program also play a major role. A survey in 2004 throughout our Malaysian State Hospital by using SERQUAL System Survey, only 5.6% of patients were dissatisfied with our healthcare services¹². Small scale individual survey was also done in our Primary care setting, in our districts, most of them reflect to the almost same figure. Apart from that the need of quality

services certification have gave us a major wave. This was carried out by implanting the ISO:9001 certification throughout our District Health Office and Health Clinics. This can classified as also modernity that later make impact to the policy changes. The other factor is the emergence of new agent in causing diseases. As an example is like the newly H5N1, avian flu virus and SARS virus. These unpredicted threats make our primary healthcare setting to be more aware of its possibilities. Multiple training and guideline or national plans were drafted to ensure our preparedness, i.e. National Influenza Pandemic Plan. This preparedness program is very important as infectious diseases are the leading cause of death worldwide and the third leading cause of death in the United States¹¹. Apart from that professional and medical technology development also has contribute to the reformation in primary healthcare services in Malaysia. As an example is the employment of family physicians in health clinics is part of its impact. Whilst in the medical technology development, some of Malaysian health clinics have been equipped with the funduscopy camera which will help in early detection of retinopathy due to diabetics.

Malaysian Strategies of Reformation in Primary Healthcare: Expanded and Focus Primary Care Services

Family Health Development Division of Ministry of Health Malaysia has reemphasized their focuses in term of latest reformation strategies to suit the local and international needs. There were three sub sections specialist care development which was started in 2005¹³. It is part of the continuity of the expansion services since year 2000. The three sub sections specialist care developments are (the conceptual framework as referred to [Figure 1](#));

1. Wellness clinical primary healthcare development
2. Primary healthcare clinical support services development
3. Primary healthcare informatics development

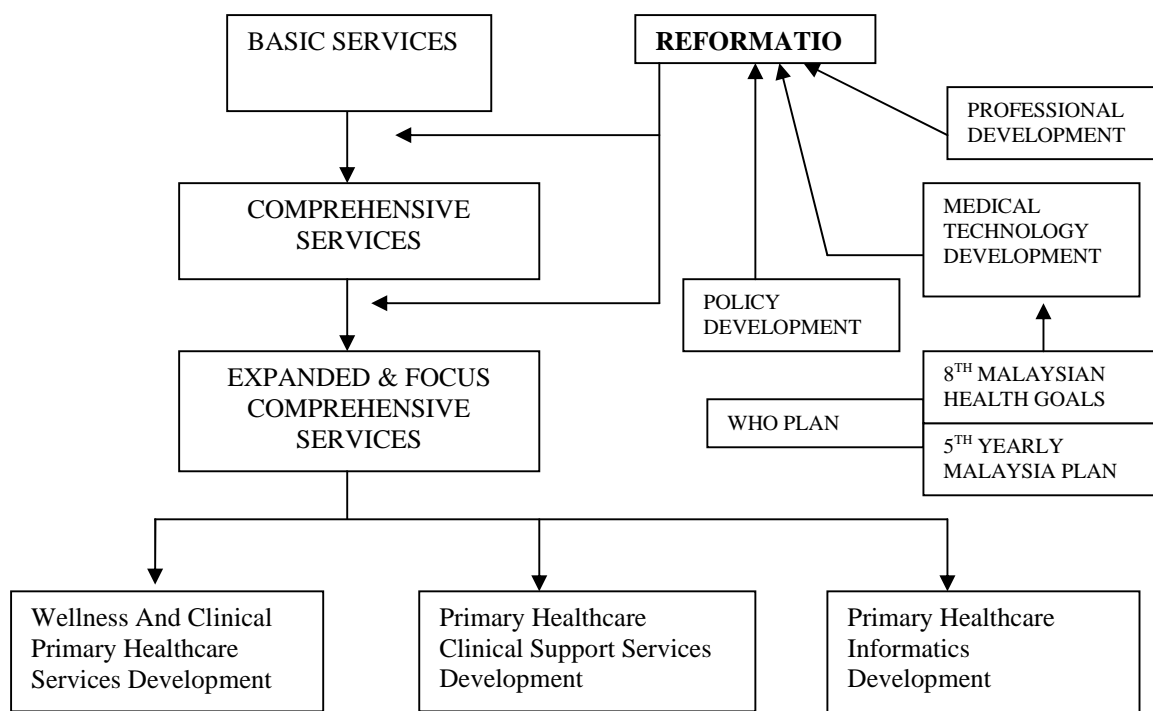


Figure 1 Conceptual Framework of Malaysian Healthcare Reformation

Wellness Clinical Primary Healthcare Development

The wellness clinical primary healthcare development is responsible in areas of planning, implementing, monitor and evaluating all the services that provided in health clinics. It enhances the focus on five phases of primary healthcare need, i.e. health promotion, diseases preventions by the wellness concepts, medical care including emergency support, disability limitation and rehabilitation¹³. These will enhance and enable the health programs and activities to be more comprehensive, integrated and efficient with optimum quality achievement. This section has a definite focus and objectives in developing the wellness scope, i.e., to strengthen and integrate the preventive activities and diseases risk assessment, acute and chronic diseases management either communicable or non-communicable and disease rehabilitation towards improving the health status of the community and up to the standard of the quality and to strengthen and enhance the cooperation and community and NGOs involvement towards the integrated, efficient and borderless primary healthcare. To further ensuring the objectives achieve, the section has developed

few strategies in implementing their action¹³. The first strategy is to actively involve the community to participate in reducing the morbidity and mortality. It is as the part of the Alma Ata strategy whereby to ensure, continue and secure the meaningful community involvement in health planning and services maintenance⁸. Secondly, is ensuring and boosting the health clinics in following the standard procedure and practices as in guideline. Thirdly, is to provide the complete and effective primary emergency care support with skilful and trained personnel with the networking and services of the secondary care. Fourthly, is to enhance the rehabilitative, palliative care and home services which to include the community in reducing the disabilities, morbidities and diseases in upgrading the quality of life¹³. There are activities were set to achieve the objectives for each sections. For the clinical wellness development, firstly, community action activities were used in improving the capacity of community involvement. In community action, few activities were introduced. This will be carried out by addressing the community activities that have impact to health, develop and strengthening the community involvement activities, coordinate and monitor the health promotion activities and provide the best guideline for the for community programs. A part from that to complete the

community action activities the section also will identify the best practice which gave the highest impact. Secondly, the section also developed activities to provide a comprehensive wellness service and care. This aim will be realized by providing a tool and method to identify health risk especially in terms of occupational and environmental areas^{13,14,15}. The provided tool must also be able to shortlist and prioritize the risk according to the magnitude of the impact. In comprehensive wellness care, coordinating and monitoring disease prevention and intervention programs is a must. This will help in realizing the total risk management as needed in primary healthcare. A part from that, evaluation of technology and tools compatibility to its output is also a must. Output of this method will be the increase of health awareness. Another specified plan is to update the protocols in strengthening the risk assessment covering not only the public sector but up to the private.

Thirdly, is to integrate all the activities that related to the disease management in the primary healthcare setting. This will later provide the optimum quality of care and services that delivered. This activity plans will be carried out by conducting an analysis of all disease prevalence, providing health intervention program method through special package programs, monitor and prioritizing the approved resources and to provide the program concept by means of optimal quality assurance following the standard operating procedure. Fourthly, is to strengthen the pre-hospital emergency care services. In this planned activity, it will consist of mapping the need for emergency services according to the severity of the patient, identifying the gaps in terms of providing the appropriate and efficient services, upgrading the needed infrastructure, facilities and networking capabilities and upgrading the link in between the primary and the secondary services. Finally, is to integrate the activities which related to the disability limitation and patient rehabilitation at the level of primary healthcare^{13,14}. These will be carried out by identifying the rehabilitation program scope which needs focus on congenital, acute and chronic diseases, enhancing the coordination and rehabilitative program monitoring, monitor the post palliative care and services implementation.

Primary Healthcare Clinical Support Services Development

The second plan in reformation of primary healthcare services is to develop the clinical support services. This plan is to ensure the human resources need and the delivery of the care were in optimum level of quality, appropriate to the

customers need which regularly monitor. The objective is to plan and manage the needs and requirement of the resources, skill development of the staffs¹³. Apart from that is to plan and control the technical support services for the primary health. The scope of this development plan is covering the professionals and paramedics, pharmacy services, pathology services, radiology services and health facility services. For professionals and paramedics development plan, it consists of planning, monitoring and evaluating the development of the human resources in primary healthcare setting. These will cover the matters which regards on the operational plan and its policy, database preparation, standard operating procedures compliance, training management, credentialing and privileging the staff and coordinating the collaboration in between the public and the private. For the pharmacy services, it is plan to provide safe pharmacy and appropriate services for the clients. These consist of development planning through preparing, evaluating and enhancing the operational policies, monitoring of drugs or medications usage, close monitoring of prescription appropriateness, upgrading the medication inventory process, providing the medication counselling usage and monitoring the quality assurance program improvement in regards with pharmacy services. Further development plan is to provide the appropriate and reliable pathological services in primary healthcare setting. These will be carried out by developing the comprehensive pathological operational plan, pathological laboratory achievement analysis, laboratory procedure monitoring, laboratory database development and upgrading of the facilities and services with ensuring the quality improvement in services. Other than that is to equipped the laboratory with appropriate facilities which comply with the approved policy and the need of its accreditation program plan.

Primary Healthcare Informatics Development

The third plan for reformation in primary healthcare is to develop its information and communication technology which synchronized with the development of health informatics in Ministry of Health. This plan will be carried out by providing the needed application which applicable to primary healthcare setting, integrating the database information which can be shared to the respected parties, strengthening the quality care by shared information and sharing the available technology with the community in terms of benefit and health plan¹³. For this purpose, there are three sub sections being developed, i.e. teleprimary care, ICT development and Community informatics. The

objectives of developing the primary healthcare informatics are to enhance the integrated and comprehensive ICT care services especially for specialist consultation and to upgrade and widen the collaboration scope of ICT services in between the public and private sector. All these aims are actually synchronized with the ninth Malaysia Plan of ICT development. For teleprimary care, there are some strategies used to achieve it means firstly are by updating the teleprimary care services up to latest development of primary healthcare services. This will carried out by developing the Teleprimary Care (TPC) in line with the development of primary healthcare, ensuring the development of primary healthcare with telehealth blueprint, ensuring the application of strategic planning in teleprimary care and ensuring the acceptance by the stake holder. Secondly is ensuring the applications were suit with the service needs. This will carried out by developing the seamless and borderless application, updating the content of system on TPC, monitoring the end user acceptance and ensuring the needed budget will received by the respected parties. Thirdly is by doing the analysis from the database for risk modelling construction. These include systemic review analysis of the available database with evidence seeking of certain diseases and marketing activity of the modelling risk for public usage. Fourthly, is to set the long term directional development of the population health information system. This strategy will be carried out by providing the long term TPC plan with common health indicator monitoring and regular report reviewing. Fifthly is to ensure all the tools and safety of systems were available and guaranteed. This will carried out by ensuring the TPC system is running well with the ensured system security with enough maintenance budgets. Finally is complete TPC system maintenance. This will carried out by updating the needs and continuously monitor the running system with trail audit^{13,14}. For the development of the ICT, few strategies are applied. Firstly is to plan the need, especially the infrastructure component. This will be carried out by preparing the needed tools, monitoring the system were always ready to function and ensuring the needed budgets are always available. Secondly is evaluating the benefit in term value change especially to the healthcare staff. This will be carried out by regulating and applying the common training for all and specialized training to the respected group. For the community informatics development, the planned and exercised strategies are by developing the community system usage or community portal system at the primary healthcare level and enhancing the optimum collaboration among the parties involved^{13,14}.

Discussion on Impact of Malaysian Primary Healthcare Reformation

Quality Improvement and Benefit of Primary Care Reformations

After the reformation of PHC in Malaysia, the quality of health care service was excellence. The benefits are toward the patient and also health workers. Minister Of Health Malaysia, during the 1st ASEAN Regional Primary Care Conference (ARPaC) in Feb 2007 said that In most health care systems in the world today primary care is the foundation of the systems and not merely one of their components^{15,16}. Government health clinics as well as the privately owned general practice clinics throughout the country constitute what is generally accepted as the primary health care or primary care system.

Primary Health Care (PHC) Structure Development

The number of the new clinic was increase as well as the modernization of the new clinic. The process of modernization of the clinics, which was started during the 7th Malaysia Plan¹⁷. As the result of PHC Structure Development, it ensure comfortable and patient friendly clinic for better care of patient and working environment. The number of patient registered was increasing. New clinic also offer medical supporting service such as better pharmacy service, pathological lab, radiological service and rehabilitations centre. Locations of clinic are near the patient house. Coverage achievements until 2005 was 88.5% within 5 km 81.1% within 3 km. 92% of urbanites is within 3km of a health facility as compared with 68.7% for the rest of the population¹⁷. Efforts to improve quality of services will be rigorously pursued during the current plan.

Human Resource in PHC

Before the reformations, the personnel who initially man the health clinics were largely paramedic and support staff. This subsequently led to the creation of a new bread of specialists, known as the Family Medicine Specialists (FMS). The number of staff increasing year by year and also new category of staff was introducing. Despite the shortage in human resources, the role of the PHC staff has expanded and their teamwork was very encouraging, especially in implementing the expanded and extended scope of PHC¹⁸. The benefits are more staff in the PHC with variety of category. Patient will get better health care service from the appropriate health provider. So, the waiting time can be shortening without compromising the quality of care.

Family Medicine Specialist (FMS)

Family Medicine Specialist in the primary health care open wide opportunity to developed primary health care service. Since there are Family

medicine Specialists in Primary Health Care after the reformation, a lot of changes in service offer to the patient. There are also increasing number of Family Medicine Specialist in the primary health care¹⁹.

Table 1 Number of Family Medicine Specialist working in Primary Health Care, 2001 to 2005.

	2001	2002	2003	2004	2005
Number of Family Medicine Specialist (FMS)	86	102	108	124	134

Source : MOH MALAYSIA Annual report 2005

Subspecialty of Family Medicine Specialist offering new services care to the patient and close to patient residence. Special care including psychosocial rehabilitation, suitable ways of diabetic care, care of children special need and stop smoking clinic, community mental health, community geriatrics, child health, women's health, rehabilitation, non-communicable disease and clinical epidemiology was initiate in 2002²⁰. This new service of primary care is to ensure quality service to the patient.

Quality Assurance Programme

Quality assurance program in Primary Health Care initiated since 1999 after the reformations²⁰. The purposes of quality assurance programs activities are to improve quality of care. Quality assurance holds a great potential for improving the quality of care, even in the most resource constrained health care systems, since it focuses on the process of health care delivery¹⁹. (MOH MALAYSIA annual report, 2002). There are 4 indicators in Primary Health Care.

Table 2 Achievements of Quality Assurance Programme indicators in Primary Health Care

Quality Assurance indicators		2004	2005
Soft skill	Appropriate management of asthma	11.0%	34.1% (median 14.0)
- 1 for each clinic	Appropriate management of diabetes	7.2%	39.2% (median 12.4)
	Appropriate admission to medical ward	97.3%	-
Hard skill	Client friendly clinic		52.4% (median 71.0)
- must for each clinic		68.0%	

Source : MOH MALAYSIA Annual report 2005

Implementation of Expanded Scope of Primary Health Care Service

Scope of primary health care service was implemented at health clinic mainly depend on the number of human resource available at the clinic.

Limitation to implement the expended scope is dew to lack of number of medical officer and nurses in the Primary Health Care Clinic ¹⁸ (MOH MALAYSIA annual report, 2003). How ever there increasing in the number of clinic implemented the service care.

Table 3 Number of Health Clinics Implemented the Expanded Scope of Primary Health Care Service, 2001 – 2003.

Expanded Scope of PHC Service	2001	2002	2003
Mental	306	279	505
Elderly	356	444	485
Adolescent	214	210	236
Rehabilitation	210	189	205
Wellness	286	243	247
Alternative Birthing Centre	143	187	359
Ultrasound	227	171	332
OccupationHealth	187	176	218
Home Nursing	314	0	174
FMS Training	28	33	61
Women's Health	416	362	90
Quit Smoking	-	-	23
Blindness	-	-	10
HIV	-	-	15
QA Diabetes	240	151	432
QA Asthma	212	109	309
QA Referral	75	66	300
QA CFC	292	140	440
QA Xray	-	-	38

Source : MOH Annual report 2003

Challenges

The Challenges in Malaysian Primary Healthcare due to Health Reformation

There are few challenges that Malaysian Primary Healthcare face in term of reformation, firstly is in ensuring the primary health care with continuous progress. In regards of any changes, the fundamental services must be continuously served. Secondly, is to ensure there is continuous effort to upgrade the primary health care of the family medicine specialists as team leader at the primary health care level. This mean the higher credits should be given to them who succeeded in establishing the sub speciality care as they were trained²¹.

Thirdly, is to establish the partnership between the health clinic and district health office particularly in developing the district health administration model. Fourthly, is to intensify the community participation of health care programs and campaign through the Health Clinic Advisory Panel. Fifthly, is to integrate the Traditional/Complementary Medicine (TCM) into the health system in an organized manner as required in TCM Policy. Sixthly, is to intensify the evaluation process for primary care services with the development of new quality assurance indicators with new approaches to measure process and outcome. Finally, is to strengthen the information and communication technology in

primary health care settings with the active involvement of health clinics in the related ICT initiatives.

New Challenges in Primary Healthcare Specifically in Health Informatics Development (9th Malaysian Plan)

There are few specific targets which planned by Ministry of Health Malaysia in ensuring the Information Technology Development in regards of Health Informatics will be establish in primary care setting. Firstly is to establish the ICT friendly environment in primary health care. Secondly is to ensure the Primary health care staff able to use ICT in their daily task. Thirdly, is to get 50% of health clinic able to use TPC (teleprimary care). Fourthly, is to ensure that the rural community easily get health information. Fifthly is to improve disease surveillance management for state and district by using TPC system. Sixthly, is to improve the quality of data collection and analysis via TPC system and lastly is to enhance of the use RKSH (rekod kesihatan sepanjang hayat) of all newborn baby and patient with chronic disease book in clinic session¹⁹.

CONCLUSION

Health reformation or changes in primary healthcare services in Malaysia is needed to bring the great wave on giving a significant impact in our

primary healthcare services for further better care for the community. Regardless whether our human resources, skilled staffs and infrastructure are shortage neither nor prepared, health reformation will result in positive impact as long as the strategy of accommodating and monitoring were taken into place as part of the reformation process.

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