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Future-proofing Malaysia's Health Workforce

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Executive Summary

- Malaysia's Human Resources for Health (HRH) planning has been generally very successful (with only some unintended consequences of success). Although it does not need major reform, it does need to consider three elements to future-proof our healthcare workforce

- The first element is ideological: to accept the benefits of central-planning; to depoliticise the HRH planning process; to allow patient and organic growth in the workforce; and to equally emphasise allied healthcare professionals (HCPs)

- The second element comprises "micro-policies" that are low-visibility and high-impact on talent retention: childcare facilities; adding performance-based promotions on top of time-based promotions; expand training into non-traditional areas like healthcare administration; and create an alternative research and publication pathway that rewards use of real-world evidence

- The final element is to prepare for highly probable future scenarios: the diminishing role of physicians and allied HCPs in the era of tech disruption; the move towards community care and away from hospital care; and a society of citizens living till 100 years old

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Introduction

Malaysia's Ministry of Health (MOH) is a behemoth. With 268,021 posts for civil servants in 2017, it is second in size only to the approximately 550,000 civil servants in the Ministry of Education.[1] The health workforce, however fit-for-purpose it is for today's needs, also needs to be future-proof for tomorrow's challenges.

This brief explores Malaysia's public sector Human Resources for Health (HRH), argues that the current planning process is competently led by technocrats, and provides several suggestions for new thinking and strategies. While doctors are important, this paper also considers the unsung heroes of Malaysia's public healthcare system — such as nurses, paramedics, and pharmacists — and considers solutions for them.

The HRH Planning System

Today, 52% of all MOH employees are paramedics or auxiliary staff, 22% are managers and professionals, and 20% are in the Execution Group. While doctors are important (34,241 of them in 2017), their numbers are correctly dwarfed by the allied Healthcare Professionals (HCPs), e.g. nurses, medical assistants, optometrists and physiotherapists.

Women dominate all categories of HCPs, except for clinical specialists. The vast majority are below 39 years old, in all HCP categories. The HCP/population ratios are higher in the west coast of Peninsular Malaysia for all categories, except medical assistants, community nurses and pharmacy assistants who are relatively more abundant in the Peninsula's east coast, Sabah and Sarawak.[2]

There are approximately 194 specialists and 3,500 house officers entering the public sector annually, with 150 specialists leaving.[3,4] In 2015 our public sector handled 60% of all outpatient consultations and 75% of all inpatient admissions, utilising 76% of all doctors and 56% of all specialists.[5,6]

Malaysia's HRH planning occurs on a few levels. Long-term horizon planning is led by the Ministry of Economic Affairs (MEA) and Economic Planning Unit (EPU) through the Five-Year Malaysia Plans that involve multiple stakeholders in creating national strategies, e.g. the 11th Malaysia Plan (2016-2020) is themed "Anchoring Growth on People".

[1] MOH Annual Report 2017.
[2] Human Resources For Health, Country Profiles 2015 Malaysia. Planning Division, MOH Malaysia.
[3] Ibid.
[4] https://today.mims.com/moh--150-specialists-leave-public-sector-in-malaysia-every-year, accessed 5 Jan 2019.
[5] National Health and Morbidity Survey 2015. Institute of Public Health, MOH Malaysia.
[6] Human Resources For Health, Country Profiles 2015 Malaysia. Planning Division, MOH Malaysia.

One level below sees the partnership between the Ministry of Higher Education (MOHE) and MOH in determining the specific tactics to achieve these strategies, in collaboration with the Public Services Department (PSD), Malaysian Qualifications Agency, professional bodies like the Medical Council, academia and civil society. The next level features more tactical allocative decisions with a smaller time and geographic scope, generally led by the Human Resources Department (HRD) in the MOH, in combination with state and district health departments.

This tri-level HRH planning and execution can be considered very successful, as it grew our healthcare human capital, diversified the workforce, and placed many more sorely-needed pharmacists, dental assistants and radiographers to where they could provide meaningful service.

However, the success of technocrats did lead to unintended consequences. As one example, the 9th Malaysia Plan (2006-2010) wanted to reduce "*acute shortages in various categories of medical and health personnel*" by "*enhancing and expanding training for medical health personnel*". Thus, the number of medical schools exploded to 33 (22 private, 11 public), with unaccredited schools accepting unqualified students into facilities without adequate instruction or equipment.[7]

Various political parties may have had their own agendas in pushing for more foreign medical schools to be accredited, e.g. in India or Russia. This thrilled many in our society, who lionise doctors — everyone's child could now wear a stethoscope. Malaysia would also enter the ranks of developed countries with a high physician density. But what seemed like the ultimate multi-win scenario proved to be different in reality.

Between 2001 and 2005, an average of 1,091 new doctors graduated and entered service as house officers annually. This number more than tripled to 3,735 new doctors annually, between 2009 and 2013. This high number caught MOH unprepared, in a few ways. The MOH had to resort to contract-based employment for these graduate doctors as there were not enough full-time positions for them. When they did enter, their training and supervision as house officers were inadequate due to increased strain on fewer specialists managing a heavier workload, and the introduction of a shift work system.

Up to 30% of house officers are not registered due to competence or disciplinary issues, possibly linked to yesterday's unqualified medical students and today's inadequate supervision. The MOHE placed a moratorium on new medical schools in 2011 in response to their own success. In summary, it is not a too-many-doctors problem; it is a too-many-too-fast problem.

[7] Chin YCM et al. (2014). Do Our Medical Students Comply with the MMC Minimum Entry Requirements? Entry Qualifications into Medical Schools: Public and Private Medical Institutions. Institute for Health Management, Ministry of Health, Malaysia.

Measures to Future-proof HRH

The HRH planning system does not need major reform, as its success is demonstrable. However, HRH future-proofing should consider the following suggestions, starting with broad ideological mindset shifts to increasingly technical nuances. When implemented in full, these suggestions will form a rising tide that also solves other healthcare challenges, while also future-proofing Malaysia's health workforce.

The first begins with ideology. The HRH planning system should clearly establish their comfort with the role of central-planning in determining future HRH needs. This will moderate market forces, because the tendency for increasingly-commercialised higher education plus an Asian society's doctor-worship will inevitably lead to more demand for doctors. Secondly, the technocrats must be insulated from political pressure in their planning process, especially the accreditation of new medical schools. Depoliticising the planning process is a strong signal that the health of Malaysian citizens is too important to be influenced by political considerations alone.

Thirdly, the planning process must allow for patient organic progress rather than unnatural growth explosions. Malaysia does not suffer from a broken-down system requiring immediate life-saving surgery; it would be unhelpful if the law of unintended consequences were to set in again. The final ideological shift concerns the role of a doctor. The WHO does not generally recommend a physician density, except for stating that 2.3 doctors, nurses and midwives are needed per 1,000 people to deliver maternal and child health effectively.[8] Malaysia comfortably exceeds this, with 5.2/1,000.[9]

A recommended physician density is not only unfeasible because different countries have different needs at different development points, it can also provide a false sense of security because it does not measure expertise, utility, geographic allocation, or relevance. Indeed, one can argue that the correct target is zero physicians for a society that is healthy, self-caring, with resilient communities and acceptance of death. Thus freed from only focusing on physicians, the HRH planning process can devote more energy to planning for allied HCPs, who bring many other benefits that will be apparent shortly.

Future-proofing HRH must also consider today's needs, not just tomorrow's tech disruption. Therefore, the retention of today's talent and specialists in the public sector must be a high priority. The brain drain is not only to the private sector, but through talent migration in a globalised workplace, for example Malaysian nurses moving to the Middle East.

Doing so requires an understanding of the most common complaints: financial (unfair wage structure, opaque and delayed promotions); professional (inadequate career development opportunities, inadequate and difficult-to-access funds for training); workplace dynamics (high workload, staff shortages, incompetent and unprofessional colleagues, unnecessary paperwork);

[8] https://www.who.int/hrh/workforce_mdgs/en/
[9] Human Resources For Health, Country Profiles 2015 Malaysia. Planning Division, MOH Malaysia.

and emotional (high stress and feeling unappreciated). Short of increasing everyone's salaries, there are small micro-policies that can be instituted to increase talent retention, improve workplace dynamics, unblock training opportunities and morally encourage all employees.

We can consider four simple ideas. Firstly, build childcare facilities in hospitals and clinics so that working parents can continue serving, especially mothers. Secondly, add performance-based promotions and training opportunities to the current time-based promotion philosophy, as human beings are driven by a sense of justice, competition and comparison. This is intended to add to, not replace, the current promotion system. Thirdly, dramatically expand the training and short-term assignment offerings into non-traditional areas like health policy, healthcare administration, health economics, resource planning, mini-MBAs and citizen science, as these are areas requiring the insights of a nurse, a midwife or a specialist doctor. Fourthly, create an alternative research and publication pathway to encourage clinician-scientists, away from a randomised-controlled trial and towards patient-reported outcomes, HRQOL, and Big Data.[10] The lesson here is that solutions should not be high-visibility and politically-glamorous projects; they should be micro-policies that creatively harness the natural and predictable human instincts for appreciation, dignity, novelty and competition.

Finally, future-proofing Malaysia's HRH must consider the following scenarios. Firstly, the role of the physician may diminish with increasingly-powerful innovations from outside the healthcare industry, such as automation, artificial intelligence, machine learning, wearables, virtual doctors and so on. This may mean we can do more with fewer doctors, but with more allied HCPs. However, it may also mean that we need more doctors, but equipped with learning agility and a passion for lifelong learning. If they are entrepreneurial, even better for Malaysia's start-up and tech economy to wrest power away from Silicon Valley; it would be wonderful if the next popular app comes from a fourth year medical student in Universiti Kebangsaan Malaysia in 2020.

The second scenario is for HRH planning to anticipate a move to community-based healthcare, rather than the hospital-based healthcare that is the current accepted wisdom. We will still need hospitals, but its role will increasingly shift to day-care procedures and coordination centres for community health, in response to better technology, higher confidence of HCPs and citizens, and stronger systems governance and communication that allows a network of nurses to fan out to the population. Healthcare-comes-to-you is cheaper, more effective and efficient, and more empowering than you-come-to-healthcare.

The final scenario for a future-proof HRH is to consider that both HCPs and the general public may have a 100-year lifespan, and plan according to an ultra-long-term horizon.[11] This may require not only the psychological courage to accept the rapid obsolescence of knowledge, but also the professional ability to up-skill and re-skill; in effect, the HCP has to learn how to learn rapidly and repeatedly. The HCP and the general public may not get to (or want to) retire at 62, because the pensions system is also not built for extended human lifespans.

[10] West SG, Duan N, Pequegnat W, et al. Alternatives to the randomized controlled trial. Am J Public Health. 2008;98(8):1359-66.

[11] The 100-Year Life – Living and Working in an Age of Longevity, Andrew Scott and Lynda Gratton, 2016.

It is possible to get lost in the intricacies of HRH planning, and miss the forest for the trees. The current central-planning system for Malaysia's HRH has worked well thus far, but will benefit from ideological mindset shifts, micro-solutions for today's talent retention challenges, and an out-of-the-healthcare-box futurist thinking. By employing creative imagination, ultra-long-term planning and confidence in their ability to execute, our healthcare technocrats will be even more successful in planning the future of Malaysia's healthcare workforce.

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