



A Political Analysis of Health Care Reform in Malaysia

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A POLITICAL ANALYSIS OF HEALTH CARE REFORM IN MALAYSIA

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Abstract

This thesis explores the political economy of health care reform in Malaysia by examining two policies in depth: first, transformation from National Health Service towards social health insurance, known as 1Care; and second, an incremental step in the form of non-profit, socially-oriented voluntary health insurance (VHI).

The Analytical Platform proposes the following problem statement: there is an insufficient understanding of the institutional and political barriers to health care reform in Malaysia. The chapter presents a literature review to provide the conceptual and scientific foundation of knowledge for the thesis. Next, the chapter describes Malaysia's political environment and health system in detail, including previous attempts at reform.

Results Statement Part I presents a retrospective political analysis of Malaysia's 1Care reform, which investigates the fundamental causes of the reform's failure. This is achieved by conducting a stakeholder analysis using Reich's *PolicyMaker* tool and methodology, to elucidate interest groups' power and position on the reform; then by applying Kingdon's multiple streams framework to provide context for the reform's failure within the agenda-setting process. The overarching conclusion of this analysis is that, although opposition groups made considerable efforts to derail 1Care, the underlying cause of the reform's failure was the lack of continuous and demonstrable political support by the Prime Minister and ruling coalition.

Results Statement Part II seeks to provide relevance to the current policy environment by extracting lessons learned from 1Care that can be applied to the ongoing non-profit VHI

scheme. Where comprehensive reforms failed, this chapter examines whether a relatively small-scale, incremental step such as VHI can be leveraged towards achieving longer-term goals.

The findings from this analysis highlight the inherently political nature of health care reform and reinforce the crucial need to conduct political economy analysis to develop reforms that are both technically optimal and politically feasible.

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CHAPTER 1: INTRODUCTION

Universal health coverage (UHC) – often described as a journey, and not a destination – is achieved by meeting several criteria: that all people are able to receive needed health services; that services are of sufficient quality to be effective; and that users may access services without fear of exposure to financial hardship (World Health Organization 2010). UHC must not only be achieved but maintained – a daunting task in the face of rapidly expanding medical knowledge and technology, aging populations, and the proliferation of non-communicable diseases. Many countries have achieved or expanded UHC by reforming their health systems, either through incremental steps, or comprehensive, wholesale health system transformations.

Financing is a pivotal component of health system reform and a major control knob which has an impact on risk protection and health status and its distribution (Hsiao 2003). Sources of financing comprise general revenue, social insurance, private insurance, community financing and out-of-pocket payment. Countries have adopted various mechanisms to finance their health systems, including National Health Service (NHS) models funded through general tax revenues, social health insurance (SHI) funded through compulsory wage-based contributions, community-based health insurance (CBHI), private health insurance (PHI), or a combination of these options.

In many cases, particularly in upper-middle income and high-income countries, there is a tendency towards adopting national health insurance as a means of increasing access to health services and achieving universal coverage (Fox and Reich 2015). Health insurance can be broadly categorized into four main types: social health insurance, private insurance, community-prepayment health insurance, and national insurance (Hsiao and Shaw 2007). Each form of insurance is distinguished by the source of financing, nature of contributions, existence of earmarked funds for health, and membership. SHI is defined by three main characteristics:

the nature of contribution is compulsory; eligibility is conferred only when a premium has been paid; and benefits and costs are specified in a social contract (2007). Different approaches to health insurance elicit different levels of financial risk protection for different sub groups within a given population.

Numerous countries have undergone, or are in the process of undergoing, health system reform. As posited by the World Health Organization, no matter how advanced the health system, ‘all countries can do something reduce the gap between the need for and the use of quality health services’ (Kutzin and Sparkes 2016). Despite the vastly different contexts and experiences of countries taking on health reform, one constant prevails: reform is an intrinsically political process. Successful reform requires political analysis and strategy at every stage of the policy cycle, from the defining and diagnosing the problem, to developing policy, to obtaining political decision (Roberts et al. 2003a).

Transforming a health system will invariably require the redistribution of resources, which is the definition of politics: making decisions about who gets what, and when (Kieslich et al. 2016). Whereas reforms in health financing are often proposed in highly technical terms – invoking tools such as cost-effectiveness analysis – what is technically optimal may not necessarily be politically feasible (Fox and Reich 2013). The process of health reform is a long one, often requiring years after implementation to create an impact, leaving policy-makers in a difficult position as they are pressured to produce results (Saltman, Figueras, and Sakellarides 1998). Countries often propose large-scale reforms in conjunction with major social, economic, and political upheaval – from post-World War II reconstruction efforts in France and Japan, to the aftermath of financial crises in Indonesia, Thailand, and Turkey (Reich et al. 2016).

This thesis is motivated by the gap between the development and implementation of health reform policy and presents political analysis as a key factor to successfully implementing

reform. I conduct a retrospective stakeholder analysis of a large-scale health system reform in Malaysia, which, despite initially receiving political backing, ultimately failed. This thesis employs a robust conceptual framework and proven analytical approaches, applying qualitative and quantitative information to elucidate factors which led to the reform's failure, and to extract lessons learned for ongoing and future reforms.

This DELTA¹ project was undertaken within the Malaysia Health Systems Research (MHSR) Study, a collaboration between the Government of Malaysia (GOM) and Harvard University. Led by senior faculty from the Harvard T.H. Chan School of Public Health, in conjunction with senior officials and a team of researchers and analysts convened by the Malaysian Ministry of Health (MOH), the MHSR study seeks to develop a clear and comprehensive strategic plan for Malaysia's health system transformation. The overarching objective of the study is to make recommendations for a sustainable health system that is equitable, efficient, effective, and responsive to citizens' needs; achieved through strengthened financing, delivery, and governance mechanisms.

This analysis primarily addresses the '1Care for 1Malaysia' reform, which laid out a plan for the country to move from a National Health Service (NHS) model of government-operated health care financed through general revenues, towards universally mandated Social Health Insurance (SHI). The 1Care reform was designed to sustain and improve upon existing universal coverage, creating a National Health Financing Agency to oversee SHI contributions, and integrating public and private health care provision under an autonomous Malaysian Healthcare Delivery System, leaving the MOH to focus on governance and stewardship (Ministry of Health, Malaysia 2009).

¹ The Doctoral Engagement in Leadership and Translation for Action (DELTA) Project is the culminating experience and capstone of the Harvard DrPH program.

Developed in preparation for the 2011-2015 Malaysia Plan, 1Care initially received political support and approval by the Prime Minister's office in 2009 (Croke, Virk, and Almodovar-Diaz 2015). Yet the ruling coalition did not promote 1Care as a political priority, and the reform failed to make a significant impact on the public agenda. The release of a concept paper on 1Care led interest groups opposed to the reform to instigate a media campaign lambasting it as 'privatization in disguise' and 'a gravy train for sharks'.² Various stakeholder coalitions mounted efforts to block the reform, and the government eventually shelved the plan as the 2013 elections neared (2015).

In 2017, the Minister of Health announced the formation of a government-linked, non-profit Voluntary Health Insurance (VHI) scheme that would organize Malaysia's high out-of-pocket spending into a more efficient vehicle to pool contributory financing. VHI represents an incremental step considerably narrower in scope and magnitude than 1Care, but with the potential to lay a foundation for future larger-scale reform.

The goal of this thesis is to provide insight and a political analysis of Malaysia's health care reform process, by conducting a stakeholder analysis of the 1Care reform; and by drawing lessons to inform the current reform climate. More broadly, this thesis contributes to the literature on health care reform and may inform policymakers in other countries on the pitfalls and barriers that must be considered when implementing reform. The thesis is organized into five chapters: the introduction, the Analytical Platform, which provides background and context for the thesis, the Results Statement Parts I and II, which present the findings of the political analysis, and the conclusion.

Chapter 2: Analytical Platform begins with the problem statement, which addresses the need for political analysis as an integral step of the reform process. The chapter then presents a

² Quotes taken from the 'TakNak 1Care' website, accessible at: <http://taknak1care.weebly.com/>

literature review, summarizing the key methodologies and theoretical frameworks for political economy analysis of health reform, and providing the conceptual and scientific foundation of knowledge for the thesis. Next, the Analytical Platform describes Malaysia's political environment and health system in detail, including previous attempts at reform, to provide context for the analysis of the 1Care reform.

Chapter 3: Results Statement Part I presents the results of the primary objective of this study: to conduct a stakeholder analysis of Malaysia's unsuccessful 1Care reform, which was publicly presented in 2010, but ultimately shelved before the 2013 general election. This is achieved through an applied political analysis of the policy reform – identifying the positions of support and opposition taken by key stakeholders, and the political, financial, ideological, and other interests involved. I conduct this analysis using Reich's *PolicyMaker* tool and methodology, and apply Kingdon's 'multiple streams' policy theory to explain why the reform ultimately failed (Reich 1996a; Reich and Cooper 1996; Kingdon and Thurber 1984).

Chapter 4: Results Statement Part II presents the results of the secondary objective: to provide relevance to the current policy environment by extracting lessons learned from 1Care that can be applied to current and future reforms. This is achieved by first assessing the progress and scope of the reform to date and identifying whether any political strategies have been deployed by the Ministry of Health after the 1Care experience. Next, I identify commonalities across 1Care and VHI in terms of their policy goals, proposed mechanisms, political environment, and potential impact on stakeholder interests. Part II closes with recommendations for the Malaysian MOH to consider in the process of implementing incremental reforms in the medium to long-term.

The final chapter summarizes the main results of Chapters 2, 3, and 4, and discusses the policy implications of this research.

CHAPTER 2: ANALYTICAL PLATFORM

2.1 Introduction

In less than six decades since its independence, Malaysia has made tremendous strides in economic growth, expanding rapidly to become an upper middle-income country, and aiming to achieve high-income status by 2020. Commensurate with the booming economy have been improvements in Malaysia's health outcomes, most notably the increase in life expectancy by more than 10 years. This gain has been driven by rapid declines in infant, child, and maternal mortality; and in considerable achievements against communicable diseases such as malaria.

However, substantial challenges remain, with rising health costs threatening the performance and sustainability of Malaysia's health system (Chee and Por 2015). Mortality rates have begun to plateau, while rates of non-communicable diseases continue to increase. Technical and allocative inefficiencies are rife, with resources concentrated on costly curative services at the secondary and tertiary level (Atun et al. 2016). There is a need to organize the large amount of private funds—out of pocket payments account for more than one third of Malaysia's total health expenditure—into a more efficient, strategic, and well-organized financing system. Global evidence indicates that adequate amounts of prepaid resources are a critical prerequisite to ensure equitable access to health services and to achieve universal coverage (Dieleman et al. 2017).

Malaysia's transition towards high-income status presents a timely opportunity to reform its health system, by enhancing the organization, financing, and provision of health services towards improved and sustainable universal health coverage (UHC). Malaysia's heavily subsidized health system provides universal coverage in relation to the standard WHO cube diagram, which defines UHC by the population covered, the services covered, and proportion of costs covered (World Health Organization 2010). However, UHC must not only be achieved,

but maintained – a daunting task in the face of rapidly expanding medical knowledge and technology, an aging population, and the proliferation of non-communicable diseases.

Beyond this achievement, to meet the growing expectations of the public, universal coverage must continuously improve in terms of equity, efficiency, effectiveness, and sustainability. While Malaysia's health care spending remains low in absolute terms and as a share of GDP, health care costs are escalating at a faster pace than GDP growth (Atun et al. 2016). Furthermore, there are persistent disparities in population health outcomes across ethnic groups and socioeconomic status (2016). Continuing and eventually improving Malaysia's universal coverage will require a reform of the health system.

With the Malaysian government's desire to maintain the current level of budget allocation for health, policymakers have had to consider other financing options to meet the growing demands and needs of the population. The political analysis of Malaysia's health care reform presented in this paper focuses on two policies in particular.

In 2009, the government proposed the '*1Care for 1Malaysia*' policy, a long-term vision to move from the prevailing tax-funded universal coverage towards adopting a national social health insurance system. For reasons this analysis will explore in depth, the 1Care proposal failed to pass the policy development stage and was scrapped prior to Malaysia's 2013 general election.

In 2017, the Minister of Health announced the formation of a government-linked, non-profit *Voluntary Health Insurance (VHI)* scheme. Initially targeting a small subset of the population, the VHI scheme will serve as a vehicle to pool contributory financing and provide a benchmark for the largely unchecked private for-profit health insurance industry. VHI represents an incremental step considerably narrower in scope and magnitude than 1Care, but with the potential to lay a foundation for future larger-scale reform.

This thesis examines these two reform efforts in detail, first by conducting a retrospective political analysis of 1Care to assess the reasons for its failure, then by applying lessons learned to the newly launched VHI reform.

The Analytical Platform begins with a statement of the public health problem that motivates the work undertaken for this DELTA project. Next, this chapter presents a review of relevant literature in political analysis of health reform, to substantiate the existence and extent of the problem, and to briefly inform on strategies and interventions that have been deployed in other contexts. The Analytical Platform concludes with a detailed description of Malaysia's health system performance, financing and delivery arrangements; as well as its political system and history of health reform, to provide justification and context for the analysis presented in the Results Statement.

2.1.1 Problem statement

Social health insurance has been described as 'perhaps the most controversial of all social programs', symbolizing the 'great divide between liberalism and socialism, between the free market and the planned economy' (Immergut 1992). Political opposition has successfully delayed, derailed, and obstructed reform in numerous countries, with political parties building platforms based on their support or opposition to reform policies. Health system reform requires a clear understanding of influential players and interest groups; and the political, institutional, social, and economic factors that formulate the context in which the proposed reform will take place (Reich 1994).

While health reform policies often emphasize technical solutions to transform the health system from its current state to a stated end goal, the pathway between these two points is rarely delineated in clear terms. There are numerous pitfalls along this path to reform, both technical and political, that could change the course of the reform, or derail it entirely. Consideration of

political economy is therefore a critical – yet all too often neglected – precursor to successful implementation of health system reform.

The problem statement that underpins this thesis is as follows: there is currently an insufficient understanding of the institutional and political barriers to health care reform in Malaysia. The subsequent theory of change posits that assessing the political economy of reform, using approaches such as stakeholder analysis and political mapping, will enable the identification of barriers to reform, and facilitate the development of strategies to overcome these barriers. This process is critical to create and implement politically feasible and sustainable policies.

2.2 Relevant literature in political analysis of health reform

2.2.1 Theory and analytical frameworks

Health reform is inherently political; its success is contingent upon strategic political maneuvering throughout the policy process (Roberts et al. 2003b). Transforming a health system will invariably require the redistribution of resources, which is essentially the definition of politics: making decisions about who gets what, and when (Kieslich et al. 2016). Whereas reforms in health financing are often highly technical, invoking tools such as epidemiological studies and cost-effectiveness analysis, what is technically optimal may not necessarily be politically feasible (Fox and Reich 2013). The influence of politics on the design and implementation of both government policies and market mechanisms is therefore a critical consideration for reform (Reich 1994).

The process of health reform is a long one, requiring years after implementation to create an impact, leaving politicians in a difficult position as they are pressured to produce results within narrow time periods and term limits in office (Saltman, Figueras, and Sakellarides 1998). Political opposition can occur through a wide range of mechanisms and delay, derail, or obstruct reform entirely. Countries often propose large-scale reforms in conjunction with major

social, economic, and political upheaval – from post-World War II reconstruction efforts in France and Japan, to the aftermath of financial crises in Indonesia, Thailand, and Turkey (Reich 1996b). Numerous theories and analytical frameworks have emerged to analyze the political economy of reform, the most prominent of which are summarized below.

The policy cycle

To enhance the possibility of a successful reform, policymakers must strategize at every stage of the policy cycle: problem definition, diagnosing causes of health sector problems, policy development, political decision, implementation, and evaluation (Roberts et al. 2003b). The cycle begins with the problem definition, which is critical to create the foundation for health system reform. Policymakers should control this narrative early in the process, as competing interests have different views of what constitutes a valid problem and an appropriate solution. Diagnosing the cause of health sector problems is a necessary step to devising an effective solution and may be achieved by exploring the five ‘control knobs’ of health sector reform – financing, payment, organization, regulation, and behavior (2003). These two stages serve as the basis for policy development, which entails both the technical design of the reform content and the political process of engaging interest groups to mobilize support for the reform.

Once the policy has been developed, the political decision-making process is set in motion. Political decision requires both political commitment and astuteness and is successfully achieved with the adoption of a reform by the executive and legislative branches of government. Policy implementation may face resistance due to required behavior changes in individuals and organizations and requires strong leadership to navigate the process. Finally, policy evaluation determines the extent to which the reform has had the desired impact; data collected throughout this stage may ultimately reveal new problems that provoke the start of a new policy cycle (Roberts et al. 2003b).

Veto points and veto players theory

Veto points theory seeks to identify steps in the political process whereby decisions are made that either advance or block a policy. Pioneered by Immergut, the theory defines veto points as ‘political arenas in which government proposals may be blocked’ (Immergut and Abou-Chadi 2010). Political decisions require agreement at various points along a chain of decisions; the shrewdest interest groups seek access to veto players at the weakest points of the chain and lobby accordingly (Immergut 1990). Veto points guide the pathways interest groups may take to influence policy outcomes. Immergut applies veto points theory to national health insurance reforms to explain how the power of a relatively minor segment of the population – medical associations – has influenced political decisions in several countries (1990). In her analysis of NHI reforms in France, Switzerland, and Sweden, Immergut demonstrates that, although the level of development, interest groups, and policy issues did not differ considerably across the three countries, the evolution and outcome of the policy process varied greatly due to the institutional design of the decision-making process in each country (1990).

While Immergut argues that there are veto points within the political system, rather than veto groups within societies, Tsebelis places greater emphasis on the veto players themselves (Immergut 1990; Tsebelis 2002). The agreement of veto players is fundamental to approve policy and change a legislative status quo; their power is established through institutional, political, and legal structures such as a country’s constitution (Tsebelis 2002). Otherwise stated, a change in the status quo requires the unanimous agreement of all veto players. Tsebelis posits that policy stability decreases with a greater number of veto players, their incongruence, and the internal cohesion of each player (Shen 2011).

Historical institutionalism

The theory of historical institutionalism describes the process of studying historical and current political-economic context to understand how institutions affect individual behaviors and drive policy development (Hacker 1998). This theory addresses big-picture, substantive questions and macro-level context, hypothesizing about the combined effect of institutions and processes over a considerable timeframe (Pierson and Skocpol 2002). Historical institutionalism highlights the essential role of path dependency, demonstrating the causal relevance of preceding events to the current policy cycle.

Comparing national health reforms in Canada, the UK, and the US, Hacker begins with a similar observation as Immergut: despite broad similarities and comparable levels of development, the three countries had vastly different outcomes of health system reform. Hacker argues that policy outcomes are a product of historical structures as much as political and institutional factors. Policies are not created in a vacuum; market structures, policy ideas, interest group strategies, and public views have already been formed in response to previous policies and shape the prevailing ideological climate (Hacker 1998). Rather than focus on specific time frames and settings in isolation, historical institutionalists analyze changes in organizational configurations over the long-term, paying close attention to interactions that continuously reshape the political landscape (Pierson and Skocpol 2002).

Agenda-setting and the multiple streams approach

Agenda-setting – the ability to influence topics of concern on the public agenda, typically through mass media – is a significant element of the health reform process, particularly at the problem definition stage of the policy cycle (Roberts et al. 2003b). The power of media to shape public opinion was first quantified in a 1968 study, where researchers found a strong correlation between the most important election issues identified by residents of a North

Carolina town and the election issues reported by local and national media (McCombs and Shaw 1972). Mass media is a powerful tool to frame problems in the public consciousness; this power is magnified in the event of a national or global disaster, serving as a catalyst for reform.

In the aftermath of Hurricane Katrina in the U.S., media stories emphasized the government's failed response over individual and community preparedness; this framed the problem around emergency response and recovery rather than mitigation and preparation, and ultimately prompted extensive changes to the Federal Emergency Management Agency (FEMA) (Barnes et al. 2008). The World Health Organization's lethargic response to the west African Ebola crisis exposed critical weaknesses in its ability to combat global pandemics, and prompted calls for extensive reforms to the institution (Moon et al. 2015).

The political process of agenda-setting is depicted by Kingdon's multiple streams approach, in which three streams – problem, policy, and political – must merge to create to a window of opportunity for policy agenda-setting (Kingdon 1995). One of the most prolific and widely recognized approaches within public policy analysis, the multiple streams framework has been applied to a variety of contexts and sectors (Jones et al. 2016). Drawing on the 'garbage can' model of organizational choice, the framework addresses how and why certain issues receive political attention (Cohen, March, and Olsen 1972; Zahariadis 2007). Problems may arise from acute events such as Hurricane Katrina or the Ebola outbreak cited above; or may represent chronic issues such as education or health care in which people share a common experience. Skilled policy entrepreneurs have the ability to recognize when the streams align and a window of opportunity opens (Ridde 2009).

Interest group theory and stakeholder analysis

Democratic systems regularly produce policies that appear contrary to the interests of the general public; this phenomenon is explored in detail by modern interest group theory (Elhauge

1991). This theory examines the mechanisms deployed by minority groups to gain disproportionate influence on the legislative process, resulting in regulations that benefit these smaller groups in exchange for extracting economic rents from larger groups (Elhauge 1991).

Stakeholder analysis is rooted in a long history of political science studies aimed at understanding the role of interest groups in influencing governmental decisions (Truman 1962). Stakeholder analysis attempts to understand the behavior, agendas, and interests of relevant actors to determine the degree to which they can influence the decision-making process (Varvasovszky and Brugha 2000). Stakeholders comprise individuals, groups, and organizations with an interest in, or face the impact of, a policy (Fox and Reich 2013).

Conducting stakeholder analysis is an integral step in developing strategies for policy reform because in the real world, policy change never achieves Pareto efficiency, and therefore groups that stand to lose from a change in the status quo are likely to resist reform (Reich 1996b). Findings from the stakeholder analysis should inform the development of strategies to manage stakeholders towards a desired conclusion (Varvasovszky and Brugha 2000).

2.2.2 Political barriers to reform: country experiences and mitigation strategies

This thesis focuses on political barriers to health reform, which involve political authority, power, and influence, and largely occur as a result in changes to resource distribution and the resulting impact on interests of powerful groups. Political barriers may arise in relation to the four explanatory variables that influence policy outcomes: interests, institutions, ideas, and ideology (Fox and Reich 2015). Interests refers to the ‘winners’ and ‘losers’ of a policy – the different groups of stakeholders leveraging their power to influence the outcome of the reform (2015). Stakeholders can create significant barriers to reform if they perceive they will be ‘losers,’ as evidenced by opposition posed by physicians’ associations in numerous countries adopting NHI. Institutions include the formal structures which may constitute veto points, such

as the legislative process, in addition to informal structures such as social and cultural norms (2015). Ideas encompass the prevailing thoughts, paradigms, and stories that can mold perceptions about the reform (2015). Finally, ideology represents a world-view, typically described along a left-right continuum, which particularly guides the progressivity of financing structures, and the preference for public versus private services (2015).

The U.S. Patient Protection and Affordable Care Act (ACA) is perhaps one of the most well-publicized recent examples of political barriers to health system reform. Despite a large Democratic majority in 2009, the ACA was barely passed through Congress, and became a driving force behind the Republican takeover of the House of Representatives in 2010, and the Senate in 2014 (Kraushaar 2015). Immediately after the ACA was passed, 26 states filed lawsuits challenging key provisions of the law (Lanford and Quadagno 2016). Much of the Republican opposition to the ACA is rooted in ideological disagreement over the role of the federal government in providing and subsidizing social services.

To overcome institutional and political veto players, the Democratic leadership engaged in ‘unorthodox’ lawmaking: forging a large and heterogeneous majority into a coherent body, making substantive changes during the merging of committee bills, and using both formal and informal summits between the executive and legislative branches (Beaussier 2012). Despite Republicans sweeping the House, Senate, and Presidency in the 2016 elections, with a core party commitment to repeal Obamacare, attempts to ‘repeal and replace’ or partially repeal the ACA failed abysmally (Park, Parlapiano, and Sanger-Katz 2017). Instead, Republicans are chipping away at key components of the ACA, with a sweeping tax reform passed in late 2017, that repealed the law’s linchpin requirement for an individual mandate (King 2018).

In Turkey, economic and political pressure to reform the health system arose due to economic crises in the early 2000s, and with the election of a legislative majority for the AK Party

(Sparkes, Bump, and Reich 2015). Notwithstanding the environment primed for reform, interests and institutional barriers posed significant challenges. Opposition to the reform came from the Ministry of Finance and Treasury, the Ministry of Labor and Social Security, the Office of the President, and the Constitutional Court. The Turkish Minister of Health overcame these institutional veto points by adopting policies through ministerial authority; facilitating institutional change to remove opposition; making strategic compromises; and, when necessary, calling on the prime minister to intervene.

Mexico's 2003 reform for social health protection, achieved through a public health insurance scheme called Seguro Popular, was rooted in three enabling factors: the epidemiological transition, the democratic transition, and relatively high rates of economic growth (Gómez-Dantés, Reich, and Garrido-Latorre 2015). In opposition to reform were several key actors: the leftist PRD party, headed by the Mayor of Mexico City; the leaders and director general of a large trade union; and prominent figures from academic institutions such as the National Autonomous University and the School of Medicine. The reform team's strategy was to maintain close collaboration and negotiation with both the Ministry of Finance and Congress, starting at the design phase. By explaining the nature of the reform, and its alignment with stated political platforms of all the parties represented in Congress, the Minister of Health was able to secure enough votes to pass the proposal.

A number of Malaysia's neighboring countries have successfully passed national health insurance reforms. In both South Korea and Taiwan, early health insurance schemes were developed for industrially strategic employees, motivated not by social protection but rather to bolster support for authoritarian regimes (Smullen and Hong 2015). As these regimes gave way to democratic systems, South Korea and Taiwan faced increasing pressure from emerging

opposition parties to expand coverage to the entire population, and NHI became a key election issue (H. Kwon and Chen 2008).

Taiwan's NHI came about through a confluence of three major conditions: unprecedented economic growth; increasing public demand for national health insurance; and the rise of political opposition in the wake of abolishment of martial law in 1987 (Cheng 2003). Prior to the establishment of NHI, 59 percent of Taiwan's population was covered through ten different public insurance schemes, such as for laborers, farmers, and government employees.

Although the NHI was several years in the planning, it was the threat of political challenge to the long-ruling KMT (Kuomintang, or Nationalist party) which precipitated the passing of an NHI bill in Parliament in July of 1994 (Cheng 2003). The opposition DPP (Democratic Progressive Party) had long espoused national health insurance; the major force underlying the timing of the reform was therefore politically motivated (Chiang 1997). As elections neared, the KMT rushed to implement NHI, and despite the reform's hasty inauguration amidst 'chaos and confusion', it was well-received by the public, and the KMT was able to maintain its hold on the country for the time being (Cheng 2003).

In South Korea, the adoption of NHI was primarily motivated by the regime's desire for political legitimization and increased development, as the country experienced record economic growth rates in the late 1980s (S. Kwon 2009). Universal coverage was achieved by incrementally phasing in coverage for population groups, starting in 1977 with mandatory social health insurance for industrial workers, and reaching universal coverage by 1989 with the inclusion of rural and urban self-employed workers (2009). Extending the scheme to the self-employed was met with high resistance, as farmers demanded an increase in government subsidy to their health insurance scheme and expanded medical facilities in rural areas (2009).

In 2000, with the success of the Democratic party under President Kim Dae-jung, and in close collaboration with previously sidelined civil society coalitions, all health funds were consolidated into a single payer scheme (H. Kwon and Chen 2008). Before the merger, horizontal inequities were rampant, as the burden of contribution for the self-employed poor as a proportion of income was considerably greater than that of their wealthier, employed counterparts (S. Kwon 2009). However, the 1997 economic crisis and the government's inability to impose supply-side cost controls threatened the financial sustainability of the NHI and resulted in excessively high healthcare expenditures (J.-C. Lee 2003). The implementation of a policy separating reimbursement for pharmaceuticals from medical care prompted widespread strikes by physicians and resulted in a deep distrust of the government by the medical profession (2003).

2.2.3 Key takeaways: Literature review and country experiences

The brief literature review presents a wide array of theories and frameworks that have been developed to analyze the political economy of reform. At their core, these theories converge on the need to systematically assess political and institutional actors, their interests, and their power to influence policy outcomes. These bodies of literature provide the conceptual and scientific foundation of knowledge that underpins this DELTA project.

In conducting a political analysis of 1Care, it was imperative to consider the motivations and actions of both external stakeholders and the coalition in power. After reviewing the breadth of available theories and frameworks, I narrowed in on two approaches that best suited the context and objectives of my analysis (this justification is described in detail in Section 3.2 of this chapter). By applying internationally recognized approaches, this thesis strives not only to provide insight into Malaysia's political process, but also to contribute to the global body of literature on political economy of reform.

The country experiences summarized above, despite occurring in very different contexts, point to the universality of political strategy as fundamental to successful reform. Major policy change has been achieved only when proponents of reform mobilized their power effectively to overcome opposition or made strategic compromises to achieve the necessary consensus. The global experience suggests that passing the health care policy alone is not sufficient, as reform is frequently used by opposition parties as a political pawn, at risk of being uprooted with the advent of every new election cycle. Policymakers should seek to entrench the reform in the legal, political, and bureaucratic framework to maximize its changes of longevity.

This thesis proposes lessons learned for Malaysia's current and future reforms, based on the outcome of 1Care. Looking to experiences from other countries also provides useful context to formulate politically feasible strategies. For example, the Mexican case demonstrates how SHI was passed despite resistance from the opposition party, academics, and trade unions – groups that also opposed 1Care. The South Korean experience shows that universal coverage can be achieved by incrementally phasing insurance coverage for population groups – a strategy that could potentially be relevant for Malaysia's VHI reform.

2.3 Malaysia's health system

Malaysia's health system combines public and private financing and delivery. The public sector is based on a National Health Service (NHS) model of government-organized health care financed through general revenues, relying primarily on historical line-item budgets. The lightly regulated private sector earns revenues primarily through fee-for-service, out-of-pocket payments by patients, and increasingly through private insurance (Atun et al. 2016). As in many countries, the MOH serves a tripartite role as the major funder, provider, and regulator of health services, with the large majority of market share for health (Chua and Cheah 2012).

This section provides an overview of Malaysia’s demographics and vital statistics, a description of the health system’s financing and delivery arrangements, and a summary of the political system and previous health system reforms. Table 1 summarizes key demographic and health system indicators for Malaysia at three points in time – 2000, 2010, and currently (latest available data).

Table 1. Key demographic and health system indicators, Malaysia 2000-2017

	2000	2010	Current	Year (current)
Demography*				
Total Population (millions)	23.3	28.3	32.3	2017
Level of urbanization (%)	62.0%	71.0%	75.0%	2017
Population growth rate (%)	2.4%	1.8%	1.3%	2017
Crude death rate (per 1,000 population)	4.4	4.6	5.2	2017
Crude birth rate (per 1,000 population)	24.5	17.2	16.1	2016
Total fertility rate (per women age 15-49)	3.0	2.0	1.9	2016
Life expectancy at birth (years)				
Female	75.0	76.8	77.4	2017
Male	70.2	71.7	72.7	2017
Population under 15 (%)	33.0%	27.6%	24.1%	2017
Population over 65 (%)	4.0%	5.0%	6.2%	2017
Service delivery†				
Total physicians	15,619	32,979	50,087	2016
Physicians per 1,000 population	0.7	1.2	1.6	2016
Total hospital beds	47,066	54,669	59,635	2016
Hospital beds per 1,000 population	2.0	1.9	1.8	2016
% of hospital beds public	80%	76%	77%	2016
Health financing‡				
Health spending per capita (constant 2010 USD)	194	418	496	2014
THE as % of GDP	3.3%	4.3%	4.6%	2015
% Total National Budget Allocation to MOH	6.3%	6.6%	9.4%	2017
GGHE as % of GGE	5.4%	7.1%	6.7%	2015
Public Expenditure as % THE	53.5%	54.7%	51.5%	2015
OOP as % THE	35.7%	35.2%	37.7%	2015
Private Insurance as % THE	4.5%	6.5%	7.7%	2015

Sources: *Department of Statistics, Malaysia †Ministry of Health, Malaysia KKM Health Facts ‡Malaysia National Health Accounts

2.3.1 Demographics and health system performance

Malaysia comprises three federal territories and thirteen states, divided into eleven states in Peninsular Malaysia, and the two states of Sabah and Sarawak in East Malaysia. With a population of just over 32 million people, the life expectancy at birth is 72.7 years for males and 77.4 years for females (Department of Statistics, Malaysia 2017). Although the population has increased steadily with an average 1.5 percent growth rate in the last decade, total fertility rate dropped below replacement level in 2015, and currently stands at 1.9 births per woman aged 15 to 49, the lowest recorded rate in the country's history (Department of Statistics, Malaysia 2016). In terms of age structure, Malaysia has a demographic dividend, with a higher proportion of working age people than dependents, and a dependency ratio of 43.6 (Department of Statistics, Malaysia 2017). The population is gradually aging, with median age rising to 28.3 years in 2017, and the percentage under 15 years dropping from 33.3 percent in 2000 to 24.1 percent in 2017 (Department of Statistics, Malaysia 2017).

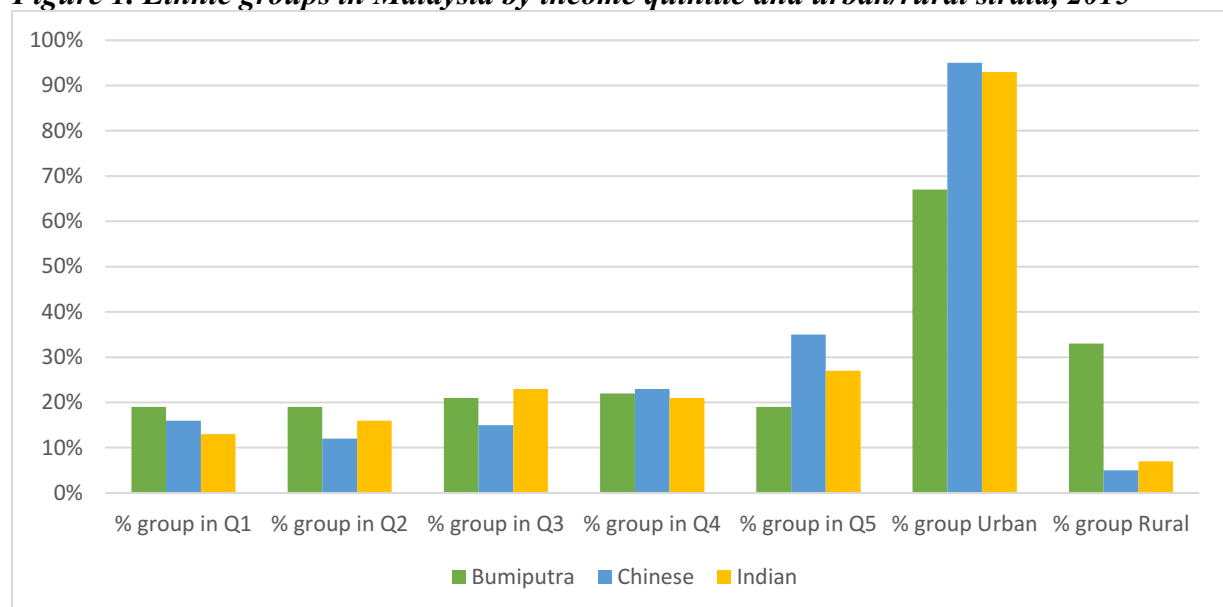
Three major ethnic groups comprise Malaysia's demographic profile: Bumiputra³ (68.8 percent of the 28.7 million citizens), Chinese (23.2 percent), and Indian (7.0 percent) (Department of Statistics, Malaysia 2017). At 3.3 million, non-citizens account for approximately 10 percent of the total population. Crude birth rates vary considerably by ethnic group: in 2015, the rate for Bumiputra was 20.5 births per 1,000 population, compared to 12.4 and 10.6 for Indian and Chinese groups, respectively (Department of Statistics, Malaysia 2016).

Although Malaysia is highly urbanized overall – approximately 75 percent of the population live in urban areas – there are notable differences in urbanization rates between ethnic groups. Malaysians of Chinese and Indian ethnicity reside almost entirely in urban areas (95 percent

³ Bumiputra is a Malaysian term (literal translation: 'son of the soil') and is defined by the federal constitution as having at least one parent who is Muslim Malay or Orang Asli (indigenous people of Peninsular Malaysia) or an indigenous native of Sabah or Sarawak (East Malaysia).

and 93 percent, respectively), whereas 33 percent of Bumiputra live in rural areas (Figure 1). Income disparities across different ethnic groups are also apparent: 35 percent of Chinese Malaysians are in the highest income quintile, compared to 19 percent of Bumiputra Malaysians. There is also considerable inequality within each ethnic group, as evidenced by Gini coefficients of 0.41 for Chinese, 0.39 for Bumiputra, and 0.38 for Indian Malaysians (Economic Planning Unit, Malaysia 2017). As this thesis will discuss in greater detail, Malaysia’s ethnic composition plays a critical role in the political landscape, with race-based parties heavily reliant on identity politics to formulate their constituencies.

Figure 1. Ethnic groups in Malaysia by income quintile and urban/rural strata, 2015



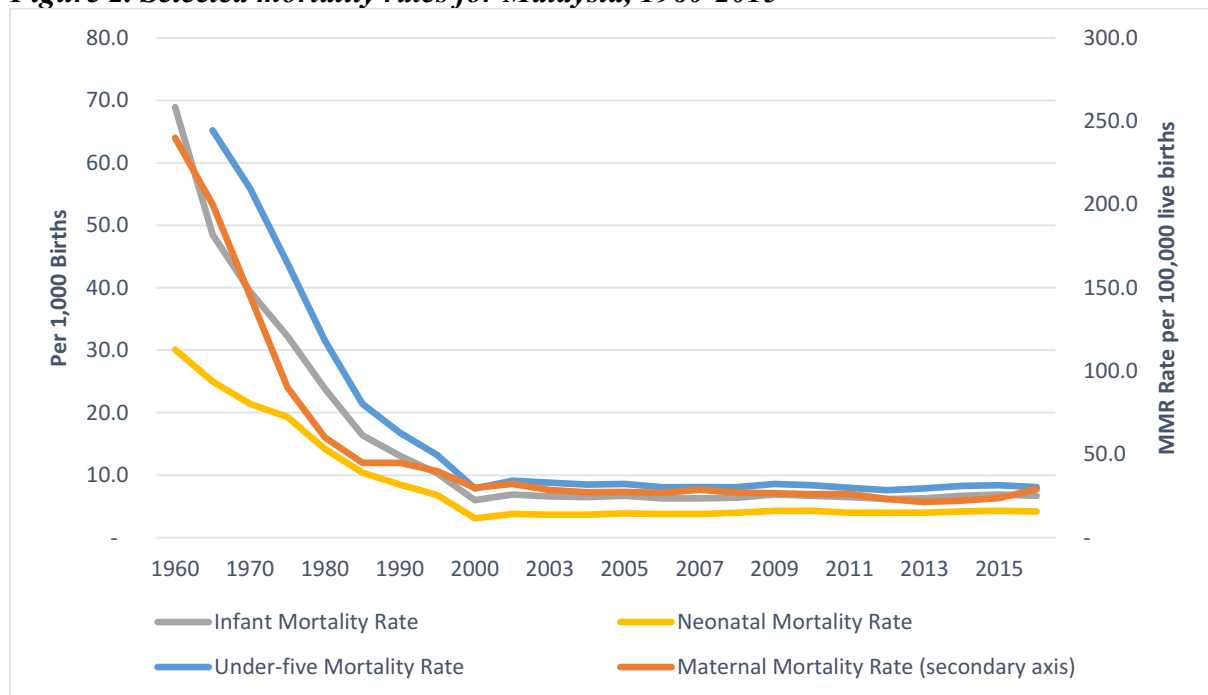
Source: National Health and Morbidity Survey (NHMS), 2015

Despite Malaysia’s higher than average income inequality, with a national Gini coefficient of 0.40 (compared, for example, to 0.33 in Japan and 0.30 for South Korea), there has been a consistent downward trend from a high of 0.56 in the last several decades (OECD 2015; Economic Planning Unit, Malaysia 2017). Furthermore, Malaysia has largely eradicated absolute poverty; the national level fell by more than half from 16.5 percent in 1990 to 8.5

percent in 1999 and to 0.6 percent in 2014, with declines across both urban and rural areas (UN 2016).

With regards to health system performance, Malaysia has made significant progress in improving health outcomes in the decades after its independence in 1957. Amongst other indicators, Malaysia’s child mortality rates are comparable to that of high-income and developed nations, having reduced the under-five mortality rate (U5MR) by more than 75 percent and the infant mortality rate (IMR) by 70 percent between 1965 and 1990 (UN 2016). In 2016, Malaysia had a U5MR of 8.1 and IMR of 6.7, compared to an average U5MR of 6 and IMR of 5 in high-income nations (Department of Statistics, Malaysia 2016; UN 2016).

Figure 2. Selected mortality rates for Malaysia, 1960-2015



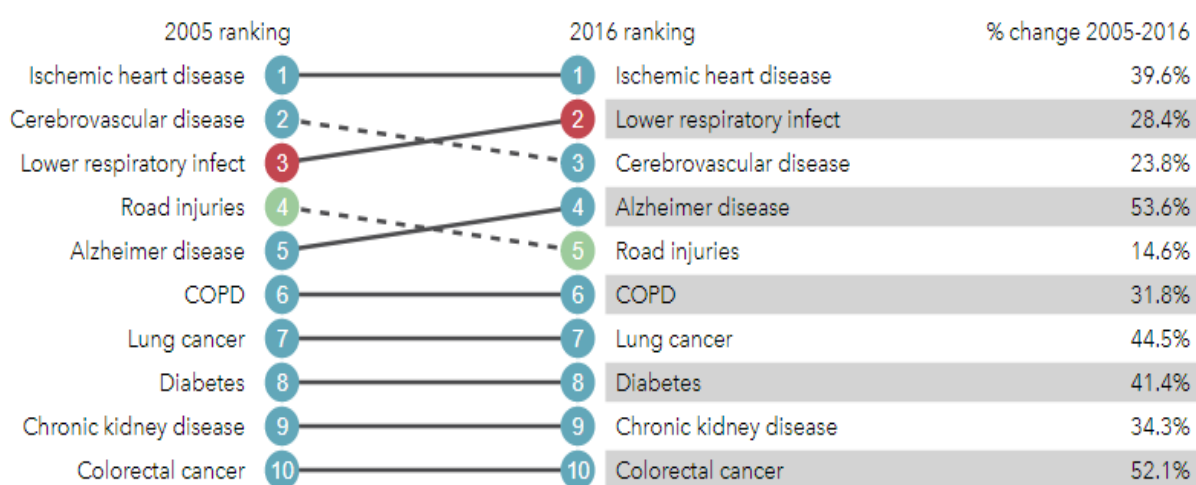
Source: Department of Statistics Malaysia, 2016

However, mortality rates overall have plateaued since 2000, and in the case of maternal mortality ratio (MMR), there has been a slight increase from 21.4 deaths per 100,000 live births in 2013 to 29.1 in 2016. Malaysia failed to meet its MDG target of reducing maternal mortality by three quarters; with a baseline MMR figure of 44 per 100,000 live births, there was only a

46 percent decline by 2015. While direct deaths cause 80 percent of maternal mortality, the rate of indirect causes of maternal death such as hypertension and eclampsia have doubled since 2000 (UN 2016). Contraceptive prevalence rates remain lower than most neighboring countries, at 54 percent in 2015, and unmet needs were reported at 15.9 percent (2016).

There has been a slow decline in avoidable mortality rates in Malaysia. Like many rapidly developed countries, Malaysia has undergone an epidemiological transition in its burden of disease, from communicable to non-communicable diseases. Eight of the top ten leading causes of death are due to NCDs, with ischaemic heart disease the number one cause, followed by lower respiratory infections and cerebrovascular disease (Figure 3). Road accidents are also a major public health area of concern, ranking as the third leading cause of death and disability combined.

Figure 3. Top 10 causes of death in 2016 and percent change, 2005-2016, all ages



Source: Institute for Health Metrics and Evaluation (IHME), 2017

Overall, the most significant risk factors accounting for the greatest disease burden in Malaysia are dietary risks, high blood pressure, high body-mass index, smoking, and high blood sugar. In the last decade, diabetes prevalence, both diagnosed and undiagnosed, has increased by 66 percent in adults, from 11.6 percent in 2006 to 17.5 percent in 2015 (Atun et al. 2016).

Prevalence of adult hypertension also remains high, although it has decreased from 37.7 percent in 2006 to 30.3 percent in 2015 (Atun et al. 2016).

Data point to disparities in health outcomes across both ethnic and socioeconomic groups, with rural and poorer populations generally faring worse. Rates of maternal, infant, and under-five mortality, as well as life expectancy, varied considerably; for example, Chinese Malaysians outlive their Bumiputra and Indian peers by four years on average (Atun et al. 2016). The rate of deaths from avoidable causes in 2008 was 139.4 per 100,000 population among Bumiputra, 139.0 among Indian Malaysians, and only 83.8 among Chinese Malaysians (Atun et al. 2016).

2.3.2 Delivery

Malaysia's dual system of health care service delivery comprises the government-led and funded public sector and a rapidly expanding private sector. The Ministry of Health is the main provider of health services to the public, and is organized at three levels – federal, state, and district. Other governmental departments that provide health services outside the MOH include the Ministry of Higher Education, which runs university teaching hospitals; the Ministry of Defense, which operates several military hospitals; the Department of Aboriginal Affairs, which provides services to indigenous populations; the Department of Social Welfare, which provides nursing homes for the elderly; and the Ministry of Home Affairs, which provides drug rehabilitation centers (Jaafar et al. 2012).

The public sector offers comprehensive services, ranging from preventive services to tertiary hospital care, with access to primary care a key thrust of the government health system (Thomas, Beh, and Nordin 2011). Community clinics (*'Klinik Desa'*) are staffed with a community nurse or midwife providing basic prevention and maternal services, and health clinics are staffed with doctors and providing the full range of outpatient services. The community clinics primarily serve rural, hard-to-reach areas throughout the country. In 2013

the MOH initiated the KOSPEN program (*'Komuniti Sihat Perkasa Negara'*), mobilizing community health workers to provide counseling on healthy lifestyle habits and risk factors for non-communicable diseases.

To serve the urban poor, the government launched '1Malaysia' clinics in 2010, staffed by assistant medical officers and offering basic medical services to senior citizens for free and at highly subsidized prices for the remaining population. The focus on prevention and primary care has enabled the country to routinely achieve essential targets such as 95 percent or greater immunization coverage, and 98 percent of births attended by skilled personnel (Ministry of Health, Malaysia 2010).

At the primary care level, the for-profit private sector predominantly operates in urban areas, providing curative and diagnostic services. In the last decade, private clinics have grown rapidly, and considerably outnumber public clinics – there were 7,335 private clinics to 3,220 public clinics in 2016 (Table 2). With the mushrooming of private clinics, market failures have been observed, as general practitioners struggle to cope with too much competition and not enough demand (Quek 2009). To a lesser extent, non-governmental health providers such as the Red Crescent Society and St. John's Ambulance provide emergency ambulatory services while other NGOs focus on specific population sub-groups and social services, such as community-based psychosocial and rehabilitation centers (Jaafar et al. 2012). Traditional practitioners and products, for Chinese and Malay medicine, also serve segments of the population (Jaafar et al. 2012).

Table 2. Healthcare provision in Malaysia, public and private, 2009-2016

	2009	2010	2011	2012	2013	2014	2015	2016
Public Hospitals								
MOH Hospitals	130	131	132	132	132	133	134	135
MOH Hospital beds	33,083	33,211	33,812	34,078	34,576	40,260	36,447	37,293
Special Medical Institutions	6	6	6	8	9	9	9	9
SMI beds	n/a	4,582	4,582	4,900	5,152	4,942	4,942	4,702
Other Govt Hospitals	8	8	8	7	8	8	9	9
Other Govt Hospital beds	3,523	3,690	3,322	3,729	3,709	3,562	3,698	3,683
Total Public Hospitals	144	145	146	147	149	150	152	153
Total Public Hospital beds	36,606	41,483	41,716	42,707	43,437	48,764	45,087	45,678
Total Public Hospital admissions	2,268,632	2,262,573	2,281,080	2,452,203	2,302,627	2,613,612	2,677,037	2,731,579
Total Public Hospital OP visits	19,357,973	19,723,583	20,355,466	21,131,727	21,622,856	22,389,340	22,734,738	23,328,541
Private Hospitals								
Private Hospitals	209	217	220	209	214	184	183	187
Private Hospital beds	12,216	13,186	13,568	13,667	14,033	13,038	12,963	13,957
Total Private Hospital admissions	828,399	869,833	904,816	971,080	1,020,397	1,083,201	1,064,718	1,073,039
Public Clinics*								
Health Clinics	808	2,833	985	1,025	1,039	1,061	1,061	1,060
Community Clinics (Klinik Desa)	1,920		1,864	1,831	1,821	1,810	1,808	1,803
1Malaysia Clinics	n/a	53	109	178	254	307	334	357
Total Public Clinics	2,728	2,886	2,958	3,034	3,114	3,178	3,203	3,220
Total Public Clinic OP visits	7,488,204	9,388,265	10,210,141	11,323,276	13,758,277	15,168,813	17,738,792	19,105,787
Private Clinics*								
Private Clinics	6,307	6,442	6,589	6,675	6,801	6,978	7,146	7,335
Total Private Clinic OP visits	2,861,443	3,174,124	3,505,591	3,853,779	3,867,668	4,000,395	3,932,361	3,821,698
Doctors								
Public	20,192	22,429	25,845	27,478	28,949	33,275	33,545	36,403
Private	10,344	10,550	10,762	11,240	11,697	12,290	12,946	13,684

*Note: does not include dental clinics and attendances

Source: Ministry of Health, Malaysia (KKM Health Facts)

At secondary and tertiary levels of care, government facilities range from district hospitals, to state-level general hospitals with resident specialists, to regional and national hospitals with multiple specialties, to tertiary special medical institutions such as the National Heart Institute. Private hospitals tend to be smaller and serve wealthier urban populations, and despite boasting newer equipment and infrastructure, often refer their more complex cases to public care. Although private hospitals are greater in number, the public sector bears a considerably larger share of patients – in 2016, 45 percent of hospitals were public, yet accounted for 77 percent of hospital beds and 72 percent of admissions in the country (Table 2).

The leading cause of admission to MOH hospitals was pregnancy and childbirth, at 23 percent of admissions, followed by respiratory illnesses (13 percent) and infectious and parasitic diseases (9 percent); in private hospitals, respiratory diseases were the leading cause of admission (16 percent), followed by infectious and parasitic diseases (15 percent), and pregnancy and childbirth (10 percent) (Ministry of Health, KKM Facts, 2017)

Whereas public hospitals face challenges to maintain infrastructure and equipment due to dwindling MOH budgets, many private hospitals have benefitted from Malaysia's policy to transform the country into a leading destination for medical tourism, receiving tax incentives to offer treatments to foreign visitors (Quek 2009; *The Economist* 2014). Winning accolades as the 'Medical Travel Destination of the Year' for three years running, Malaysia's medical tourism been identified as one of the National Key Economic Areas to meet aspirations towards high-income status by 2020, and received a RM30 million allocation in the 2018 budget (*New Straits Times* 2017a).

Public health care facilities face an overwhelming share of inpatient admissions, and suffer losses in highly qualified and specialized staff who prefer to work in the lucrative private sector (Ministry of Health, Malaysia 2010). An estimated 300 doctors and 50 specialists leave the

public sector annually, mostly opting to join the private sector (Quek 2009). Various public-private partnerships have been formed to address budgetary insufficiencies and brain drain, such as the full-paying patient (FPP) scheme, piloted in 2007 in Hospital Putrajaya with a planned expansion to 32 public hospitals across the country. The FPP scheme allows specialists in public hospitals to practice in a private wing after work hours, giving patients access to specialist care at prices competitive with private hospitals, while allowing government physicians to retain fees from consultations and treatments.

Corporatizing public hospitals is another government mechanism to retain specialists, enabling salaries above the thresholds established by the civil service remuneration structure (Chee and Barraclough 2007). A notable early example is the National Heart Institute, (IJN, Institut Jantung Negara), which was separated from Kuala Lumpur Hospital in 1992 and corporatized as a government-owned entity, providing high-quality cardiovascular and thoracic services at subsidized prices 25-50 percent lower than leading private hospitals (Chee-Khoo 2015).

Physical access to care is relatively high, although disparities exist: 92 percent of the urban population live within three kilometers of a health facility, whereas this figure is 69 percent for the rural population, with the greatest distances in East Malaysia (Jaafar et al. 2012). Private facilities are highly concentrated in urban areas, according to market demand, and as a result, those living in rural areas are largely denied access to private care, whether they can afford to pay for it or not. Although the government endeavors to distribute resources equitably based on need, the deployment of facilities and human resources for health remains uneven, with particular disparities in rural areas (Quek 2009).

Quality in public facilities is largely regulated by the MOH, through the production of clinical practice guidelines, the conduct of technical audits on the performance of clinical staff and their management of diseases, audits on patient mortality cases, and establishment of key

performance indicators (KPIs) (Jaafar et al. 2012). Regulation of the private sector was codified by a law passed in 1998, but the legislation was not enforced until 2006, and even then, has been weak due to lack of political will and resources (Abdullah 2007). Hospital accreditation is voluntary (other than hospitals geared to medical tourism); 40 percent of MOH hospitals and 10 percent of private hospitals were accredited as of July 2010 (Jaafar et al. 2012).

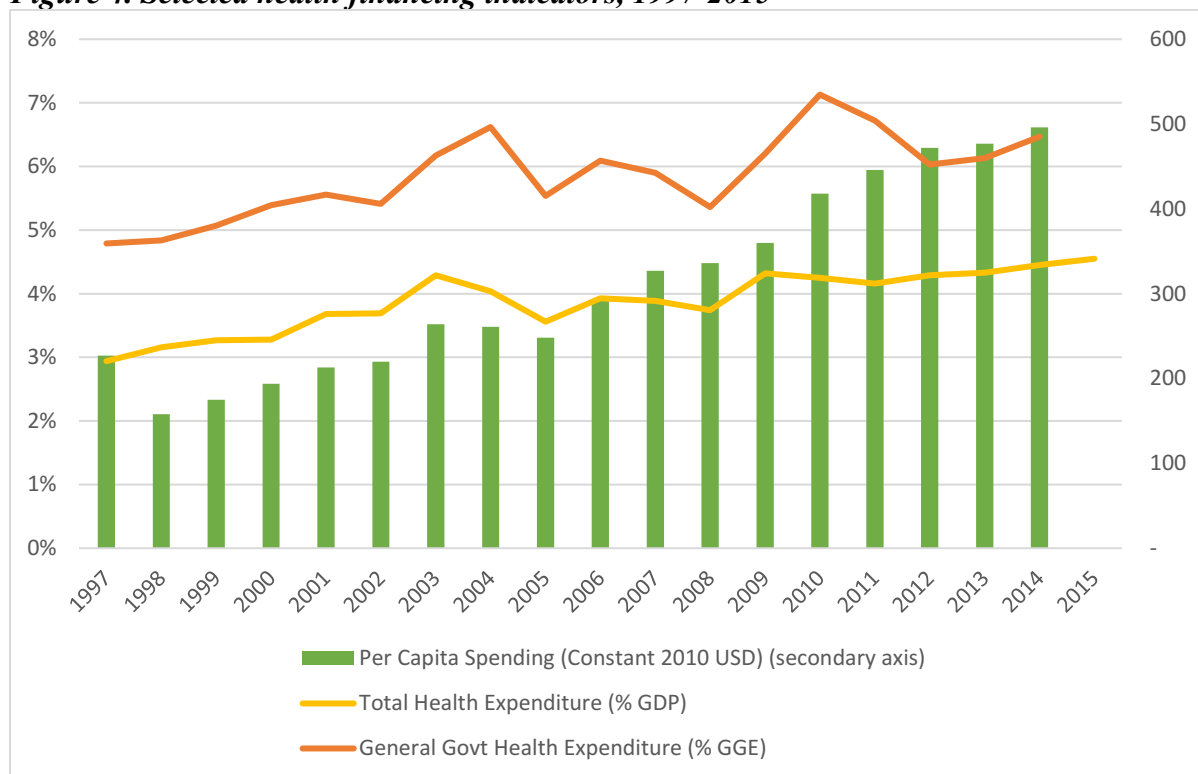
User satisfaction with both public and private services is generally high, although patients indicate dissatisfaction with process-related quality indicators in the public sector (such as waiting times, choice of physician, and availability of private rooms), and high costs in the private sector (Atun et al. 2016). Respondents of the 2015 National Health and Morbidity Survey (NHMS) indicated 81 percent had a good or excellent overall impression of public hospitals, compared to 72 percent for private hospitals (2016).

2.3.3 Financing

In 2015, Malaysia spent USD 13.5 billion on health, equivalent to 4.55 percent of its GDP, a steadily increasing trend from a total health expenditure of 2.94 percent of GDP in 1997 (Figure 4). Per capita spending on health more than doubled in the same period, at USD 277 in 1997 to USD 496 in 2014. Government expenditure on health as a proportion of general government expenditure increased over time, although with fluctuation from year to year, ranging from 4.79 percent in 1997 to 6.47 percent in 2014. (*See Annex 1 for health financing indicators*).

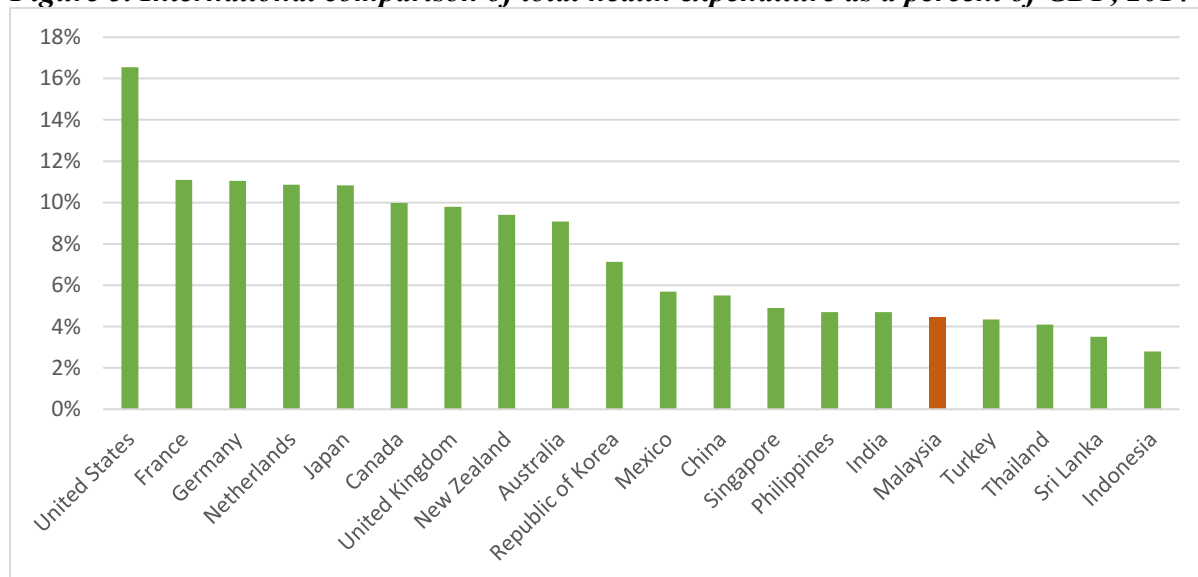
Due to strong economic growth – an average annual increase of 8.6 percent in the last decade – Malaysia has been able to substantially increase spending on health while maintaining a low overall burden, both in terms of percentage of GDP and in absolute spending (Atun et al. 2016). Notwithstanding this increase, Malaysia’s spending on health as a share of GDP remains low by international comparison to middle and high-income countries (Figure 5).

Figure 4. Selected health financing indicators, 1997-2015



Source: Malaysia National Health Accounts (MNHA Unit 2017)

Figure 5. International comparison of total health expenditure as a percent of GDP, 2014



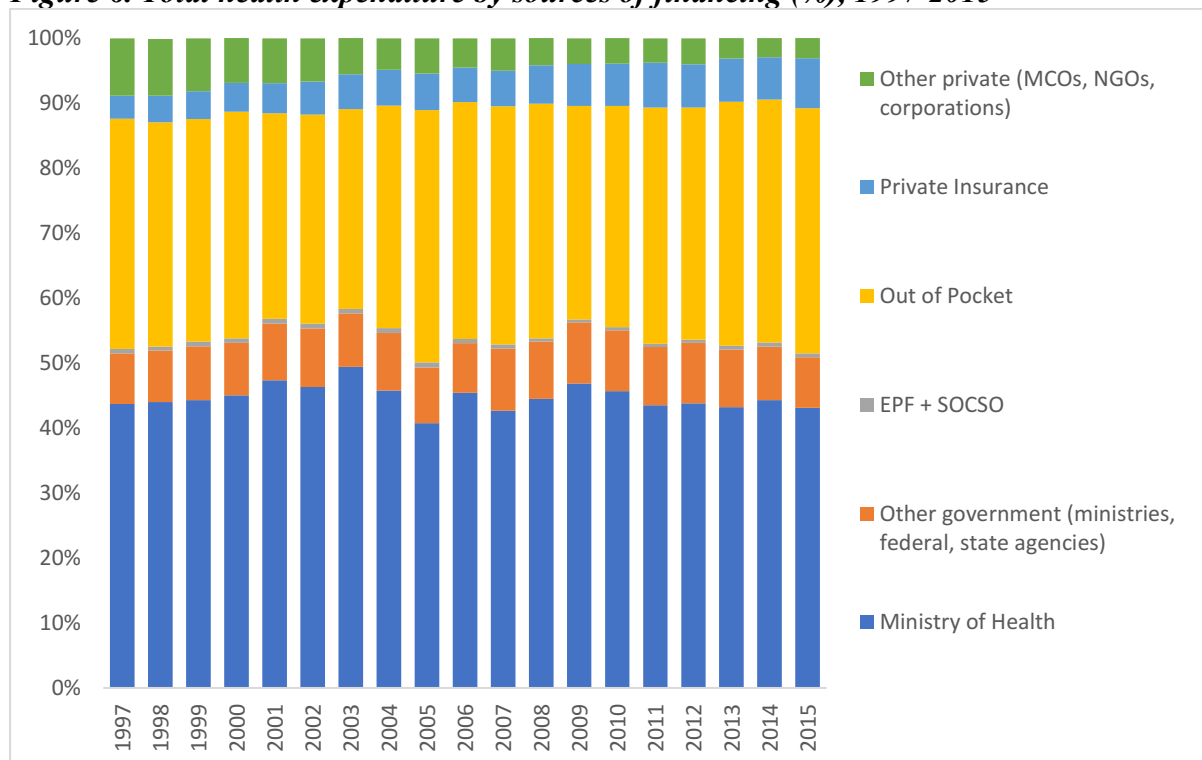
Source: OECD Health expenditure and financing database, WHO Global health expenditure database

Malaysia’s total health expenditure is almost evenly split between public and private sources of financing, at 51.47 percent and 48.53 percent respectively in 2015, a proportion that has remained relatively constant over time (Figure 6). Government health services are almost

entirely paid for through a centralized, top-down, line-item budget system which cascades downwards from the Ministry of Health to state, district, and facility level (Atun et al. 2016).

The MOH is the primary source of financing, accounting for 43.10 percent of THE in 2015, and private out-of-pocket spending the second largest source of financing, amounting to 37.73 percent of THE (Figure 6). After the MOH, public sources of financing primarily comprise other ministries and government agencies, accounting for 7.80 percent of THE in 2015. Private insurance remains a relatively small percentage of THE, at 7.70 percent in 2015, but this share has more than doubled since 1997.

Figure 6. Total health expenditure by sources of financing (%), 1997-2015



Source: Malaysia National Health Accounts (MNHA Unit 2017)

Malaysia’s two social security funds, EPF and SOCSO, account for a very minor contribution towards total health expenditure, at less than one percent of THE. The Employee Provident Fund (EPF) is a compulsory retirement savings plan and allows withdrawals to buy healthcare equipment or to cover medical expenses for a predetermined list of critical illnesses. SOCSO

(Social Security Organization) contributions are also mandatory and provide medical and financial coverage for work-related injuries and disabilities.

The majority of health spending goes toward curative care at hospitals. In 2015, 60 percent of public sector expenditure went to hospitals, followed by 16 percent for ambulatory services and 10 percent on general administration and insurance; for private sector expenditure, 45 percent went to hospitals, followed by 26 percent for ambulatory services and 18 percent on retail sales and medical goods (MNHA Unit 2017). Curative care accounted for 60 percent of private and 65 percent of public expenditure, whereas prevention and public health accounted for 3 percent and 7 percent of expenditure, respectively (MNHA Unit 2017).

Largely due to the heavily subsidized public healthcare system, financial risk protection is high, with only 1.44 percent of households experiencing catastrophic spending of more than 10 percent of total household expenditure in a given month (Rannan-Eliya et al. 2013). Moreover, the incidence of catastrophic spending has decreased sharply, from 0.36 percent in 1998 to 0.16 percent in 2009 (2013). Although out-of-pocket spending is high, it appears to be concentrated in the middle and high-income groups that purchase private services and remains low relative to GDP, at 1.72 percent.

Provider payment in the public sector is made through fixed monthly salaries, along a government regulated salary scale with bands corresponding to professional classification and grade. Public sector health workers receive an additional 20 to 50 percent of gross salary as allowances and are entitled additional benefits such as maternal leave, pre-service and in-service training, and highly subsidized medical care and access to higher-class wards at public hospitals.

In the private sector, more than two-thirds of provider revenue is financed through out-of-pocket, fee-for-service payments from patients, with a smaller proportion of revenue from

insurance reimbursements (Atun et al. 2016). Providers may set their own prices, but consultation and procedure fees are subject to a threshold specified by the government under the Private Healthcare Facilities and Services Act. General practitioners, in particular, rely on prescription of medications as a major source of revenue, and as such have strongly opposed proposals to separate dispensing and prescribing functions (*Malaysiakini* 2017).

2.3.4 Key takeaways: Malaysia's health system

This section describes Malaysia's health system in detail – its performance, financing and delivery arrangements, demographic and disease profile – which provide necessary technical context for a political analysis of health system reform. These details may partially substantiate claims made by stakeholders against the wholesale transformation of the health system. Opponents of 1Care frequently asked why there was a need to fundamentally change what has been described, both nationally and globally, as a universal, equitable, and relatively low-cost system. They also cited a critical consideration to undertaking health care reform in Malaysia – the population's long-held entitlement to a highly subsidized, widespread public system.

Global evidence points to an association between economic development and a health financing transition characterized by an increase in spending per capita on health, and a decrease in the share of out-of-pocket financing (Dieleman et al. 2017). Although Malaysia has experienced the former, with per capita spending climbing from USD 227 in 1997 to USD 496 in 2015, out-of-pocket spending not only remains high but has increased slightly in the same period, from 35 to 37 percent of total health expenditure (MNHA Unit 2017).

Malaysia's spending on health at 4.55 percent of GDP is low in comparison to countries at similar levels of economic development; government spending on health accounts for approximately 2.32 percent of GDP and represents less than 10 percent of the federal budget. This level of spending is considerably lower than globally recognized targets such as the 15

percent budgetary allocation Abuja target and the 5 percent of GDP for government spending on health proposed by global experts (Mcintyre, Meheus, and Røttingen 2017).

These observations substantiate the existence and extent of the problem posed earlier in this chapter; and are also critical to understanding why the reform failed. 1Care was primarily a solution to future, anticipated problems, rather than an immediately perceived need. Fighting to change what is currently accepted as a well-performing system will inherently entail a difficult political battle, requiring a deep understanding of the barriers to reform and strategies to overcome them. As a result, not only was 1Care susceptible to attacks from external stakeholders but would also have required very strong political backing from the ruling coalition in order to succeed.

2.4 Malaysia's political system and previous health care reforms

Since gaining independence from the British Empire in 1957, Malaysia's political system has been characterized by 'deeply entrenched racial pillarization and class stratification' (M. L. Weiss 2014, p7). By the middle of the nineteenth century, the British colonial system had expanded economic activity across Peninsular Malaysia, importing Chinese, Indian, and Indonesian laborers in record numbers and permanently shifting the demographic landscape from predominantly Malay to a pluralistic society (Hirschman 1986). The British segregated these new groups geographically, socially, and economically from the local population, maintaining the Malay feudal social structure in the countryside whilst funneling immigrant workers to mines, plantations, and cities (1986).

Whereas Malay elites were granted relatively high status and allowed to join the lower ranks of colonial services, Chinese elites (and to a lesser extent, the Indian community) reaped economic benefits but were politically marginalized by the colonial powers and were never accepted as permanent residents (1986). Japanese occupation during World War II fueled the

flames of inter-racial conflict even further, as Chinese were explicitly targeted for persecution, whilst Malays were recruited as police officers to fight against the Chinese communist-led resistance movement (Kheng 2012). These ethnic divisions continued to deepen post-independence, and more than sixty years later, race-based parties remain the political norm.

This section provides a brief description of Malaysia's political system and economy, and an overview of previous health system reforms. Table 3 summarizes key economic and political indicators for Malaysia at three points in time – 2000, 2010, and currently.

Table 3. Key economic and political indicators, Malaysia 2000-2017

	2000	2010	Current	Year (current)
Economy and business*				
GDP (current USD), billions	93.790	255.017	296.536	2016
GDP growth (annual %)	8.9%	7.0%	4.2%	2016
GNI per capita, PPP (current international \$)	11,880	20,020	26,900	2016
GNI, PPP (current international \$), billions	275.425	562.876	839.033	2016
Ease of doing business (rank of 190, 1= best)	n/a	23	24	2017
Employment†				
Labor force participation rate (%)	65.4%	63.7%	68.1%	2017
Unemployment rate (%)	3.1%	3.3%	3.3%	2017
Informal employment (% total employment outside agriculture)	8.0%	9.3%	11.4%	2015
Corruption‡				
Corruption perception index (0-highly corrupt, 10-very clean)	5.0	4.4	4.9	2016
Corruption index ranking	36 of 91 countries	56 of 178 countries	55 of 176 countries	2016
Democracy**				
Democracy index rating (0-worst, 10-most democratic)	n/a	6.19 Flawed democracy	6.54 Flawed democracy	2017
Democracy index ranking (of 167 countries)	n/a	71	59	2017

Sources: *World Bank †Department of Statistics, Malaysia ‡Transparency International
**Economist Intelligence Unit

2.4.1 Politics in Malaysia

Overview of Malaysia's political system⁴

Like many former British colonies, Malaysia follows the Westminster system: a parliamentary democracy with a federal constitutional monarch, the Yang di-Pertuan Agong, who serves as head of state and appoints the Prime Minister as head of government. The executive branch is nominally headed by the King, but executive authority is exercised through the Cabinet, which is led by the Prime Minister and subject to the authority of Parliament.

The Federal Parliament is bicameral, comprising the upper house (*Dewan Negara*, council of the nation), with 70 members, 44 appointed by the King and 26 elected by state assemblies; and the lower house (*Dewan Rakyat*, council of the people, or House of Representatives), with 222 members elected by voting districts. Bills presented before the two houses need a simple majority to pass, while changes to the codified federal constitution require a two-thirds majority in both houses. Each of the thirteen states has a unicameral state legislature, or *Dewan Undangan Negeri*, elected from single member constituencies.

The Constitution stipulates that general elections must occur every five years, although the Prime Minister may request the Parliament be dissolved by the Yang di-Pertuan Agong at any point within this time period. Members are elected to the House of Representatives from single-member constituencies using the first past the post voting method, and the majority party forms the federal government. State elections are usually held simultaneously with parliamentary elections, but the timing is determined at the state level.

Whereas the principle of separation of powers is stipulated under Article 121 of Malaysia's Federal Constitution, critics have argued that this separation is abused in practice, with power

⁴ Note: much of this section summarizes information from (Moten 2008) and (M. L. Weiss 2014).

‘monopolized’ in the hands of the Prime Minister (Karamudin 2009). As the Prime Minister and Cabinet are also Members of Parliament, there is an overlap between the executive and legislative branches. Bills presented before Parliament need only a simple majority to pass, and with the tendency of MPs to vote along party lines, there is a strong likelihood that legislation originated by the ruling coalition will be passed.

There are also no limits on the amount or nature of powers that Parliament can delegate to the executive branch; many laws are passed as a product of delegated legislation rather than parliamentary legislation (*The Sun Daily* 2009). The Prime Minister, and not Parliament, decides on key judiciary appointments: judges of the Federal Court, Court of Appeal, and Higher Court; in addition to other high-level positions such as Chief Justice, Police Chief, and the MACC Chief (Malaysia Anti-Corruption Commission).

Given this arrangement, there are few formal checks on the Prime Minister’s ability to dictate policy while he has the support of his party (Croke, Virk, and Almodovar-Diaz 2015). The influence of the executive branch over both judiciary and legislative branches of the government has prompted opposition politicians to call for major reforms and clear laws defining and determining the doctrine of separation of powers (Karamudin 2009).

Malaysia’s political history

Barisan Nasional (BN) and its predecessor, the Alliance Party, have ruled the country since independence, occupying a centrist, pro-Malay political position, with opposition parties flanking either side (Ong 2014). The Alliance coalition was formed when the United Malays National Organization (UMNO) joined with the Malaysian Chinese Association (MCA) and Malaysian Indian Congress (MIC) to contest a joint slate of candidates in the 1952 municipal elections in Kuala Lumpur. Combined, these three parties attracted massive support from their respective ethnic constituencies, and the Alliance continued to prevail through the 1964 general

elections, under the leadership of Prime Minister Tunku Abdul Rahman of the UMNO party. UMNO has been the dominant force within the BN coalition since its inception; all six of the elected Prime Ministers have been the leader of the UMNO party (Table 4).

Table 4. Prime Ministers of Malaysia, from Independence in 1957 to present day

Prime Minister	Party	Term in Office
Tunku Abdul Rahman	Alliance Party (UMNO)	August 1957 – September 1970 (13 years)
Abdul Razak Hussein	Alliance Party (UMNO)	September 1970 – January 1976 (5 years)
Hussein Onn	BN (UMNO)	January 1976 – July 1981 (5 years)
Mahathir Mohamad	BN (UMNO)	July 1981 – October 2003 (22 years)
Abdullah Ahmad Badawi	BN (UMNO)	October 2003 – April 2009 (5 years)
Najib Razak	BN (UMNO)	April 2009 – Present (9 years)

In the first two decades of its rule, the Alliance outlined key priorities in its First and Second Five-Year Plans: economic growth and industrialization, promotion of external trade, consolidation of the internal market, and development of key sectoral policies (Khai Leong 1992). Although the plans promoted the economic prosperity of the poor and rural populations (which mainly comprised Malays), there were no specific race-based provisions. As the 1969 elections neared, the Alliance began to explore explicitly pro-Bumiputra policies; meanwhile, two Chinese-majority opposition parties, the Democratic Action Party (DAP) and Parti Gerakan (Malaysian People's Movement Party) were gaining considerable support (1992).

The 1969 general election, in which the Alliance saw its poorest performance yet, having lost the popular vote and a significant number of parliamentary seats to the opposition, sparked massive racial riots in Kuala Lumpur, resulting in casualties of up to 600 people (Khai Leong 1992). The riots led to the declaration of a national state of emergency, suspension of Parliament, the resignation of PM Abdul Rahman, and have since been ‘seared into the Malaysian national consciousness’ (Thillainathan and Cheong 2016). In the aftermath of the

riots, Prime Minister Tun Abdul Razak Hussein introduced a pro-Bumiputra affirmative action program, officially known as the 1971-1990 New Economic Policy (NEP).

The NEP was succeeded in 1991 by Prime Minister Mahathir Mohamad's National Development Policy (NDP), which continued in large part to pursue the affirmative action policies laid out by its predecessor. Mahathir, Malaysia's fourth and longest-reigning Prime Minister, is alternately credited as a visionary who single-handedly transformed and modernized Malaysia's economy, or as a corrupt, inconsistent ruler responsible for the deeply ingrained cronyism that remains a feature of Malaysian politics today (Jomo and Way 2003).

Barisan Nasional evolved from the Alliance coalition in 1973, expanding to include regional parties from East Malaysia's states of Sabah and Sarawak, in addition to opposition parties such as Gerakan and the Pan-Malaysian Islamic Party (PAS). BN has won all thirteen post-independence elections, and maintained consecutive wins of its two-thirds majority in Parliament until 2008, when it won just 51 percent of the popular vote, and 63 percent of parliamentary seats (Nawab 2014). In the views of some political analysts, this dominance has largely been aided by the manipulation of electoral rules, gerrymandering, the use of repressive laws, and disproportionate access to the media (Ong 2014).

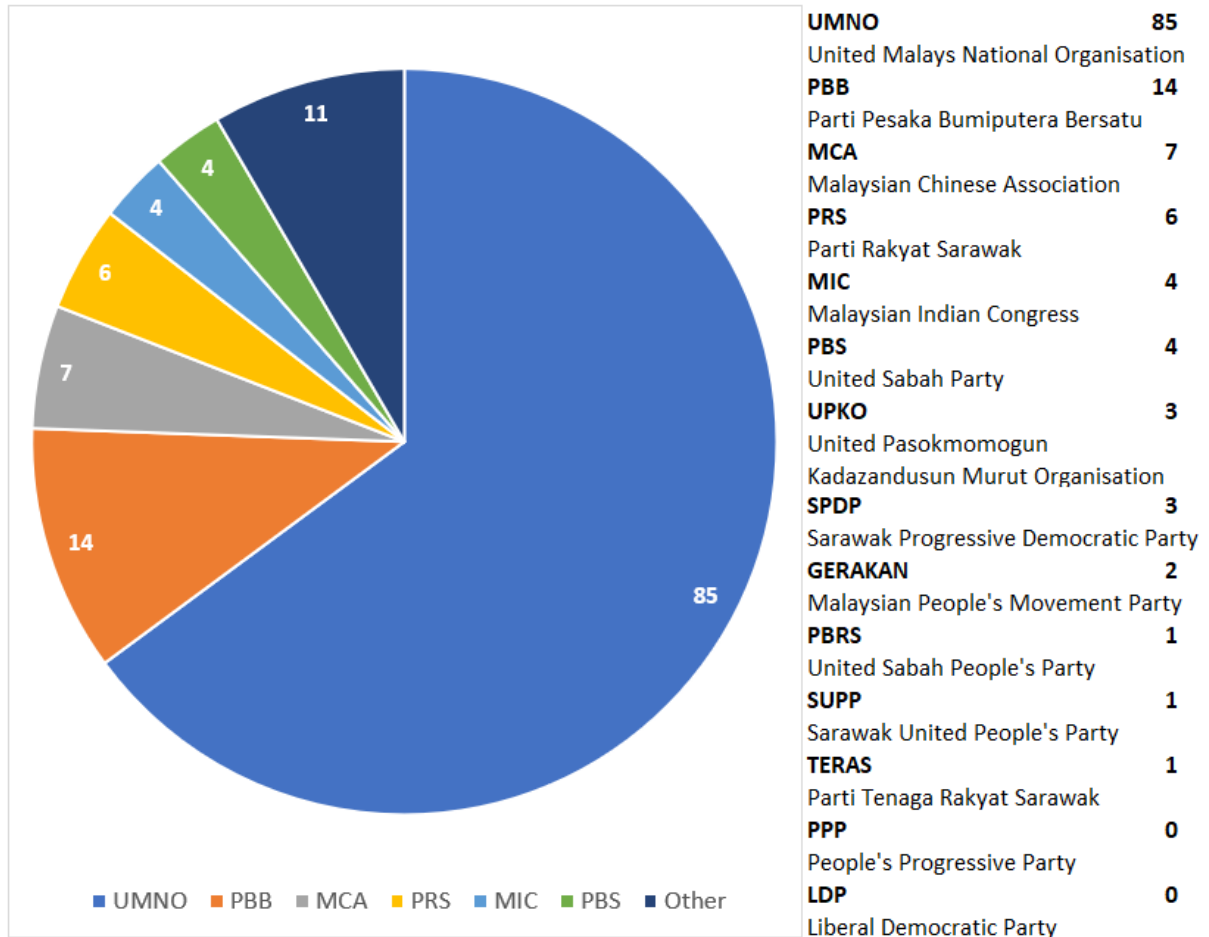
Thirteenth General Election and the current political landscape

The thirteenth general election, held on May 5, 2013, proved to be the most fiercely contested in Malaysia's history. A previously inconceivable scenario was unfolding, with victory uncertain for Barisan Nasional as the opposition coalition Pakatan Rakyat (PR) launched a credible threat to the ruling coalition (Ng et al. 2015). Ultimately, BN won the election, retaining its power with a simple but comfortable 28-seat majority, winning 133 of 222 seats in Parliament. Not only was this a reduction in seats from the previous election, once again

denying a two-thirds majority in Parliament, but for the first time BN lost the popular vote – with only 47 percent, its lowest popular support in history.

The election demonstrated an important political shift, particularly within Peninsular Malaysia: first, an increase in Chinese support for PR (mostly at the expense of BN’s DAP), and second, a major swing in the urban electorate against BN, further widening the country’s rural-urban rift (Ng et al. 2015). Two thirds of the seats BN won in Peninsular Malaysia were classified as rural; BN regained some of the Malay-dominated rural seats it had lost in 2008, but also lost a number of urban seats in traditional BN strongholds (2015).

Figure 7. Barisan Nasional parliamentary seats, by component party, as of January 2018



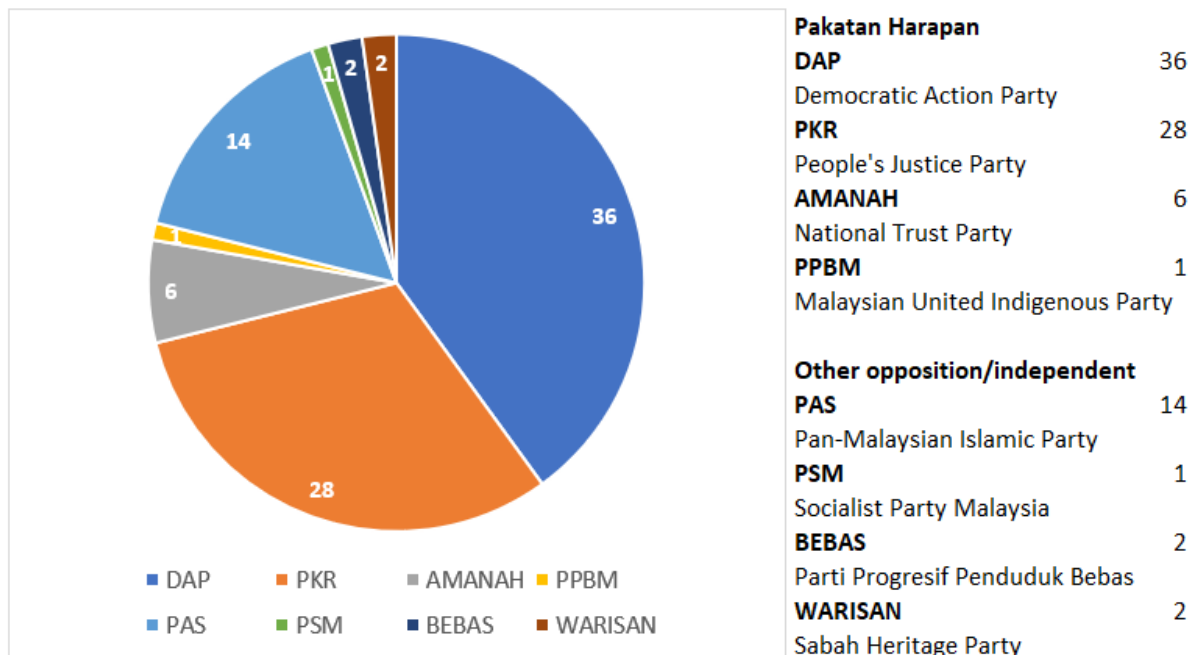
Source: Malaysian Parliament Official Portal⁵

⁵ Accessed from the Government of Malaysia official Parliamentary website: <http://www.parlimen.gov.my>

At present, the BN coalition comprises 14 parties, holds 131 parliamentary seats, and is led by Prime Minister Najib Abdul Razak of the UMNO party, in office since 3 April 2009. With UMNO’s majority within the BN coalition and overwhelming dominance within the Cabinet, there have historically been few formal checks on the policymaking power of the Prime Minister (MacIntyre 2001).

PM Najib’s tenure has been marked by several positive economic liberalization measures, but has also been plagued by scandal, most notably the 1MDB corruption probe which alleged that more than USD 1 billion of the sovereign wealth fund had been routed to the PM’s personal bank accounts (Wright and Clark 2015). The scandal resulted in widespread protests, spearheaded by the Bersih movement (Coalition for Clean and Fair Elections) and the issue by prominent politicians, including former PM Mahathir, of the Malaysian Citizens’ Declaration demanding Najib’s resignation (*Malaysiakini* 2016a). Najib not only managed to ride out the political crisis but tightened his grip on power by pushing through a controversial National Security Council bill that vastly expanded his executive powers (*Al-Jazeera* 2016).

Figure 8. Opposition parliamentary seats, by component party, as of January 2018



Source: Malaysian Parliament Official Portal

Pakatan Harapan was formed in 2015 as the direct successor to Pakatan Rakyat (PR), the opposition coalition comprising the People's Justice Party (PKR), Democratic Action Party (DAP), and the Pan-Malaysian Islamic Party (PAS), which had been expelled from the BN coalition in 1977. The PR coalition was dissolved in 2015 due to the growing rift between PAS and DAP over the former party's desire to implement Islamic sharia law. Harapan now holds 71 parliamentary seats and comprises four parties: the original DAP and PKR, and two newly formed parties: Amanah (National Trust Party) and PPBM (Parti Pribumi Bersatu Malaysia, or Malaysian United Indigenous Party).

As Malaysia's 14th general election nears (with a date of May 9, 2018 recently announced), the race between BN and Harapan has taken on increasingly surreal proportions with the nomination of Mahathir Mohamad as the Harapan opposition candidate. Despite PM Najib's troubled regime, infighting amongst Harapan's component parties and the unpopular nomination of Mahathir have considerably weakened the threat of the opposition coalition (Kathirtchelvan 2017).

Economic policies

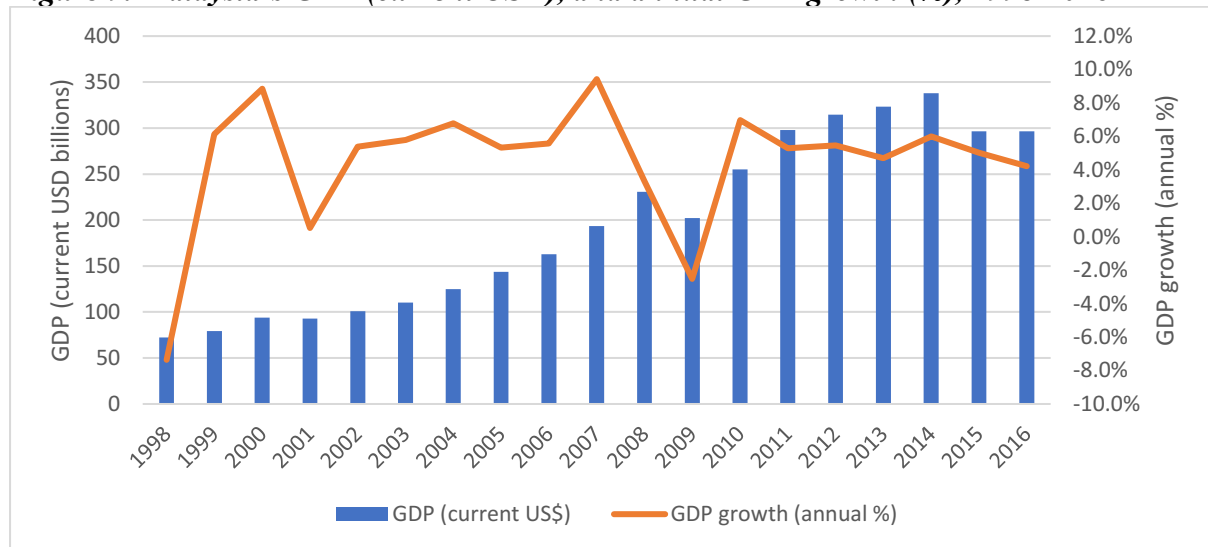
Barisan Nasional's long-standing objective is to propel Malaysia from an upper-middle income country to high-income status by 2020. As such, BN has consistently run on a platform of economic growth, adopting a development strategy of poverty eradication through job creation. Swathes of rural forest area gave way to plantations, and the government targeted heavy industrialization in urban areas – between 1982 and 2014, 20 percent of new jobs created were in manufacturing, and 30 percent in the trading sector (UN 2016).

As a result, Malaysia's economy grew on average by 6.5 percent per year between 1970 and 2010; in the aftermath of the 2009 financial crisis, the economy has continued to grow steadily and is forecast to expand by 5.2 percent in 2018 (UN 2016; *The Star* 2017). Manufacturing

accounts for the largest economic driver, with a share of 22 percent of GDP, followed by wholesale and retail trade (19 percent) and finance (11 percent) (Bank Negara Malaysia, 2017).

Figure 9 displays Malaysia’s growth in GDP over the last two decades.

Figure 9. Malaysia’s GDP (current USD), and annual GDP growth (%), 1998-2016



Source: World Bank Development Indicators Database

The New Economic Plan is arguably one of the most contentious issues in Malaysian politics, and remains a frequent topic of debate to this day (Ong 2014). Unique to affirmative action programs, the NEP targeted a majority group, as Bumiputra comprised approximately two-thirds of the population. The NEP directed public expenditure at institutions exclusively serving the Bumiputra, giving preferential selection for tertiary education and employment opportunities, and creating quotas for housing, shares in listed companies, and awarding of contracts (Thillainathan and Cheong 2016).

Unlike other affirmative action programs, the NEP defined its target population by racial delineation, rather than using income as the primary criterion; as a result, disadvantaged non-Bumiputra are excluded from NEP benefits (2016). The pro-Bumiputra provisions of the NEP have largely continued in successive economic plans proposed by BN, from Mahathir’s 1991 National Development Policy to Najib’s 2012 Bumiputra Economic Transformation Roadmap.

The 1970s and 80s were a time of rapid transformation for Malaysia; while much of the world faced an economic crisis, the discovery of petroleum provided an immense boost to Malaysia's economy (Chee and Barraclough 2007). The main drivers of the economy shifted from rubber and tin to palm oil and petroleum; in later years, manufacturing and tourism became increasingly important. A major component of BN's development strategy was to deploy price controls on basic goods and services – more than half the items on the consumer price index – to maintain low inflation rates; and to provide subsidies on public services, such as education, healthcare, public transport, water and electricity, as well as on fuel and basic food items such as rice, cooking oil, flour and sugar (UN 2016).

In 2010, citing budgetary issues, and guided by the Performance and Delivery Unit (PEMANDU), Prime Minister Najib announced plans to roll back government subsidies, beginning with fuel, sugar, and cooking gas (*Malaysiakini* 2010a). In 2015, the government began implementation of a Goods and Services Tax (GST) of 6 percent, having announced this intention more than a decade earlier in the 2005 budget. The measure was pushed through despite a widely unpopular reaction to the new tax, including an anti-GST rally of over 50,000 people in May 2014 (*Malaysiakini* 2014).

Nevertheless, the Najib administration also implemented a number of well-received economic programs, such as 1Malaysia People's Aid (BR1M), a cash handout program for low-income families, regardless of race, launched in 2012 and continuing annually through the 2018 budget. Najib's New Economic Model (NEM), which launched the Government Transformation Programme (GTP) and Economic Transformation Programme (ETP) were favorably received both domestically and internationally and proposed key results areas to improve the country's social and economic indicators in line with the goal to reach high-income status. Other initiatives included the distribution of various rebates – from smartphone and cable box

purchases to new tyres for taxi drivers – proved popular despite many analysts decrying the handouts as blatant vote-buying (Grant 2013).

2.4.2 Health system reforms prior to 1Care

Although healthcare has not been the top priority of Malaysian political issues, there have been numerous attempts to reform the health system in the last several decades, both wholesale and incremental, which achieved varying degrees of success. Malaysia inherited a welfare-oriented, National Health Service-style system established by the British colonial power, with public hospitals providing subsidized care, and primary services mainly provided by general practitioners (Barracough 2000). In the first few decades after independence, building infrastructure and developing capacity in human resources to ensure access to quality health services was the main priority of Malaysia's government (Croke, Virk, and Almodovar-Diaz 2015). The driving force during this time was 'Malayanization' – the replacement of British staff with locals, resulting in the proliferation of public and private universities, many of which set up medical schools (Chee and Barracough 2007).

The first wave of reforms began in the 1980s under PM Mahathir, as rising incomes and increased urbanization propelled health care demand and utilization upward. In 1983, the incoming Mahathir administration announced a new privatization policy under which the state would actively cooperate with and foster the private sector. Mahathir's 'Malaysia Incorporated' policy envisioned the government as the caretaker for an enabling environment, in terms of infrastructure, deregulation, liberalization, and macroeconomic management, but with the private sector as a main engine for economic growth (Chee and Barracough 2007).

Initially, the impact of this watershed policy was slow to reach the health care sector – only 5 percent of hospital beds were private in 1980 – but major change came about with the privatization of the Government Medical Stores in 1994 and the main hospital support services

in 1996 (laundry, engineering, cleaning services, clinical waste management, and equipment maintenance) (Chee-Khoon 2015). The government awarded fifteen-year concessions for these services; without exception, every contract was given to companies with direct links to the ruling coalition. The manufacture, procurement, and distribution of drugs to all government hospitals and clinics was awarded to Remedi Pharmaceuticals, wholly owned by the government-linked company UEM (United Engineers Malaysia), and with close ties to UMNO (Gomez and Jomo 1999). The five hospital support services – which collectively amounted to the second largest expenditure category, after remuneration, in government hospitals – were contracted out to three companies, one of which belonged to a conglomerate owned by Mahathir’s son, another which was owned by UEM, and the third which was owned by UMNO-linked entrepreneurs who had previously worked under Musa Hitam, the Deputy Prime Minister (1999).

Concurrent with Mahathir’s privatization policies, private hospitals flourished from the 1980s onward; with a laissez-faire regulatory policy and no measures in place to moderate their rapid growth, private hospitals more than tripled between 1980 to 2016, from 50 to 187, and private beds as a share of total increased from 5.8 to 24.2 percent (Ministry of Health Malaysia 2017). Several incentives were enacted to facilitate this growth, such as providing industrial building allowances for hospitals, service tax exemptions for medical equipment, and tax deductions for pre-employment training expenses (2007).

Corporatization, or the restructuring of government hospitals into corporate-type entities, was another policy promoted by the Mahathir administration. In the early 1990s, public teaching hospitals attached to the medical faculties of Universiti Malaya, Universiti Sains Malaysia, and Universiti Kebangsaan Malaysia were all corporatized, as was the National Heart Institute (IJN,

or Institut Jantung Negara) cardiology and cardiothoracic center of Kuala Lumpur Hospital (Barraclough 2000).

In 1999, the government announcement of plans to corporatize all Ministry of Health hospitals was met with resounding opposition, led by the Citizen's Health Initiative (CHI), a civil society group initiated by members of the Malaysian Medical Association, the Consumer Association of Penang, and academics from Universiti Sains Malaysia. The initiative carried considerable political heft, through its support by the leading DAP opposition party and the politically well-connected Malaysian Trade Union Congress, both of which deployed significant manpower to campaign against the corporatization policy (Chee-Khoo 2014). Amidst mounting and vocal public displeasure, the plan was shelved in the run-up to the November 1999 general election (Chee and Barraclough 2007).

As the government broadened its search for alternative private financing mechanisms, a separate savings account, 'Account III', was established in 1994 within the Employees' Provident Fund (EPF), into which 10 percent of the funds would be diverted to be used for treatment of critical illnesses. However, as detailed in Section 2.3.3, EPF remains an insignificant source of health financing, as only a small proportion of EPF members have sufficient funds in their Account III to cover major illnesses (Chee and Barraclough 2007). In 2000, EPF entered into an agreement with the Life Insurance Association of Malaysia (LIAM) allowing contributors to authorize the use of Account III funds to cover health insurance premiums (2007). In contrast to the stated role of the EPF as an employee social security fund, the insurance scheme drew criticism for its use of differential, discriminatory premiums for aged and high-risk subscribers (2007).

Maintaining health care provision as a primary welfare function of the state, whilst simultaneously promoting state investment in the private health care sector, represents a

contradictory yet prevailing ideology of the ruling coalition. An estimated 40 percent of all private hospital beds in the country are owned by government-linked companies (Chee-Khoon 2015). The most prominent investor in private hospitals is a state corporation, owned by the investment arm of the Johor State government. Khazanah Nasional, a government-linked investment company and Malaysia's sovereign wealth fund, is the majority shareholder of IHH Healthcare Berhad, the largest private healthcare group in Asia, and owner of Parkway Pantai Ltd, the largest private healthcare provider in Southeast Asia.⁶ This investment in private healthcare has frequently been the target of civil society groups, such as the CHI and the Coalition Against Healthcare Privatization (CAHCP).

In 2009, the Ministry of Health drafted a proposal for a comprehensive reform that would drastically restructure the financing and delivery of the health system towards national Social Health Insurance. This reform, known as 1Care for 1Malaysia, is the subject of this thesis, and is analyzed in depth in the following chapter, Results Statement Part 1.

2.4.3 Key takeaways: Malaysia's political system and previous health reforms

Amidst the plethora of political actors and developments described in this section, several key takeaways should be considered to frame the analysis presented in the subsequent chapters. Undeterred by mounting corruptions scandals and growing opposition, Barisan Nasional and its leading UMNO party continue to dominate. Despite BN once again losing the two-thirds Parliamentary majority, PM Najib has successfully managed to consolidate his power and increased his stronghold over the country. A controversial new bill, the National Security Act, was passed in December 2015, granting the government unprecedented powers to conduct search and seizure without warrant and to declare martial law (*Al-Jazeera* 2016). Political

⁶ From the IHH website, accessible at: <http://www.ihhhealthcare.com/about-overview.php>

analysts are largely predicting a win for BN in the upcoming 14th general election (K. Lee and Chia 2018).

BN's strategy to date has relied heavily on the rural Bumiputra vote, but demographic changes will have a major impact on the political landscape in the near future. As Malaysia strives for high-income status and is expected to reach 80 percent urbanization by 2030, political battlegrounds will shift even further along urban and rural lines, with voting patterns for race-based parties likely to decline significantly (Ng et al. 2015). Simultaneously, the population is aging rapidly. Parties will need to identify with rising demands of urban voters on issues such as cost of living, income inequality, and education to succeed. With increasing demand and rising living costs, healthcare may receive greater prominence on the public agenda – if so, policy entrepreneurs looking to reform the health system should watch closely for opportunities to introduce new policies.

In reviewing the myriad health reforms passed in Malaysia, there is a clear emphasis on cultivating the private sector, in line with the country's national goal for economic development. The 10th Country Health Plan states that 'all government agencies and Ministries are required to ensure that projects and programmes were in line with the 5 National Missions Thrusts'; the first of which is 'to move the economy up the value chain', and the fourth 'to improve the standard and sustainability of quality of life' (Ministry of Health Malaysia 2010). The plan also emphasizes the national strategic direction of a 'competitive private sector as the engine of growth'.

Economic growth is the driving motivation for major policies undertaken by the government; reforms emphasizing social benefits at the expense of this growth (whether real or perceived) will likely have a harder time receiving strong support of the ruling coalition. Furthermore, the privatization efforts and the corporatization of public hospital functions begun in the 1980s

remain firmly in place, and the ever-increasing government stakes in the private sector create a complex web of political and financial interests that will be difficult to untwine.

CHAPTER 3. RESULTS STATEMENT PART 1: '1CARE FOR 1MALAYSIA' – AN APPLIED POLITICAL ANALYSIS

3.1 Introduction

Since the country's independence in 1957, Malaysian citizens have been entitled to a highly subsidized, geographically widespread, publicly provided health system (Chee-Khoo 2014). Based on a National Health Service (NHS) model, the government-operated health care system is financed through general tax revenues and offers universal access to a wide range of services at nominal out-of-pocket cost. The Ministry of Health serves a tripartite role as the major funder, provider, and regulator of health services, accounting for the majority of market share for health (Chua and Cheah 2012). The lightly regulated private sector providers earn revenue through fee-for-service, out-of-pocket payments, and increasingly through private insurance (Atun et al. 2016). *(See Annex 1 for a summary of key health financing indicators.)*

While the Malaysian state has maintained its integral role in financing and delivering healthcare, the system has nevertheless transformed due to the increased prominence of the private sector, driven by rapid economic growth. Malaysia's ruling coalition since independence, Barisan Nasional (BN), has consistently campaigned on an economic platform, strongly encouraging private sector growth, foreign investment, and medical tourism. In the wake of economic expansion in the 1980s and 1990s, then-Prime Minister Mahathir Mohamad announced the first wave of privatization reforms, with increased investment by state corporations and private investors in health care (Nehru and Tran 2013).

Several key reforms in the 1990s pushed the privatization agenda further, beginning with the corporatization of Malaysia's tertiary cardiac care center, Institut Jantung Negara (IJN). This was followed by contracting-out to private firms of the government's drug distribution system, and public hospital support services such as laundry and clinical waste management (Chan

2010). In 1999, a government proposal to corporatize additional hospitals and medical centers was met with voracious opposition, primarily by the Citizen's Health Initiative, a coalition formed by the Malaysian Medical Association, NGOs, consumer associations, and trade unions (Leng and Hong 2014). Elections were nearing, and the proposal was shelved, with the government even conceding additional funding to public hospitals.

With economic growth came increasing urbanization, a burgeoning middle class, and the demand for private health care; resulting in a rise in specialist clinics and corporate, investor-owned hospitals (Barraclough 2000). Between 1980 and 2016, the number of private hospitals more than tripled, from 50 to 187, and private beds as a share of total increased from 5.8 to 24.2 percent (Chee and Barraclough 2007, Ministry of Health Malaysia 2017). The predominantly public health system has given way to a segmented, dual-tiered system – a private sector for paying consumers, and a public sector for the remainder of the population (Chee 2008).

Concurrently, there has been a growing mismatch in the resource distribution between the public and private sector. At the time of 1Care's drafting, only 30 percent of specialists were employed in the government sector, but they served 70 percent of hospital admissions throughout Malaysia; 11 percent of primary care clinics were publicly owned, but handled 38 percent of patient visits (Chee-Khoon 2015, Ministry of Health Malaysia 2010).

Despite the burgeoning private sector, the entitlement to good quality, heavily subsidized services was and remains a core public expectation of the government's role in health care provision and financing. Outpatient primary care at hospitals and clinics, including consultation, medicines, and laboratory exams, incurs a charge of a single Malaysian Ringgit (equivalent to USD 0.25); the price for specialist care is RM5. The government abolished all token payments for primary care for senior citizens in 2012. For civil servants and their

dependents, entitlement to free government health care and higher-class wards has been a standard provision since the British colonial era.

Consequently, the public health care system is considered a ‘safety net’ for Malaysians, and they are fiercely protective of this right to highly subsidized access (Chee and Barraclough 2007). Even to those who can afford private care, the public sector plays an important role. Public facilities purportedly serve as a price bulwark to restrain the private sector from escalating charges – although this impact may be muted by the decline in perceived quality due to long waiting times, chronic staff shortages, and stock-outs of medicines (Chee-Khoo 2015).

3.1.1 The 1Care for 1Malaysia proposal

In 2009, the Malaysian Ministry of Health produced a concept paper describing the transformation of Malaysia’s health system. Titled ‘1Care for 1Malaysia’, the reform proposed to improve upon the existing universal coverage, by moving Malaysia from a general tax revenue-based financing system towards a national social health insurance model (Leng and Hong 2014).

Developed in preparation for the 2010 Malaysia Health Plan, 1Care initially received political support, including approval of the Prime Minister and his Cabinet (Croke, Virk, and Almodovar-Diaz 2015). The release of a concept paper on the policy prompted physicians’ groups and other stakeholders opposed to reform to instigate a media campaign lambasting 1Care. Seizing their opportunity, political opponents and interest groups rallied against 1Care, and the government quietly shelved the plan as the 2013 elections neared (2015).

Malaysia’s 1Care experience demonstrates the intensely complex and political nature of reform; particularly health reform, which often proposes drastic change to the existing social contract between citizens and the government. Health reforms may require new provider

payment mechanisms, introduce patient payments, or limit reimbursable services to those who can afford them (Glassman et al. 1999). Transforming a health system is intrinsically political as it requires the redistribution of resources, requiring a determination of who gets what, and when (Kieslich et al. 2016). Realistically, policy change cannot achieve Pareto efficiency, and therefore groups that stand to lose from a change in the status quo are likely to resist reform (Fox and Reich 2013).

In Malaysia, where entitlement to a subsidized public system is ingrained in the national consciousness, and where the government encourages a flourishing private sector, reforming the health system necessitates a policy that is technically feasible and politically desirable, both to actors within the ruling coalition and to external stakeholders.

3.1.2 Goal and structure of this chapter

There is currently an insufficient understanding of the institutional and political barriers to health care reform in Malaysia. Assessing the political economy of reform, using approaches such as stakeholder analysis, enables the identification of barriers to reform, and the development of strategies to overcome them. This process is critical to create and implement politically feasible policies.

The goal of this chapter is to provide insight into the reform process in Malaysia, by conducting a retrospective political analysis of the unsuccessful '1Care for 1Malaysia' policy, and by drawing lessons learned to inform further reform attempts. More broadly, this analysis contributes to the literature on health care reform and may apprise policymakers in other countries of the pitfalls and barriers to consider when implementing reform.

In this analysis, I examine the positions taken by stakeholders and the interests affected by the reform, and assess how stakeholders played a role in blocking the reform using Reich's

PolicyMaker tool and methodology (Reich 1996; Reich and Cooper 1996). Next, I address where in the policy process stakeholder opposition intervened, and contextualize the factors leading to the reform's failure, by applying Kingdon's multiple streams approach (Kingdon 1995).

The paper is organized as follows: Section 3.2 presents the methodology and conceptual frameworks that motivate and structure the analysis. Section 3.3 describes the 1Care reform in detail, delving into the goals, mechanisms, and timeline of the policy. Section 3.4 presents the results of the political analysis of Malaysia's 1Care reform, by identifying and creating a political mapping of the power, position, and interests of key stakeholders. Section 3.5 applies Kingdon's policy streams approach to assess the barriers that contributed to blocking the reform within the context of the policy process. Section 3.6 discusses the fundamental causes for 1Care's failure, and addresses limitations of the approach.

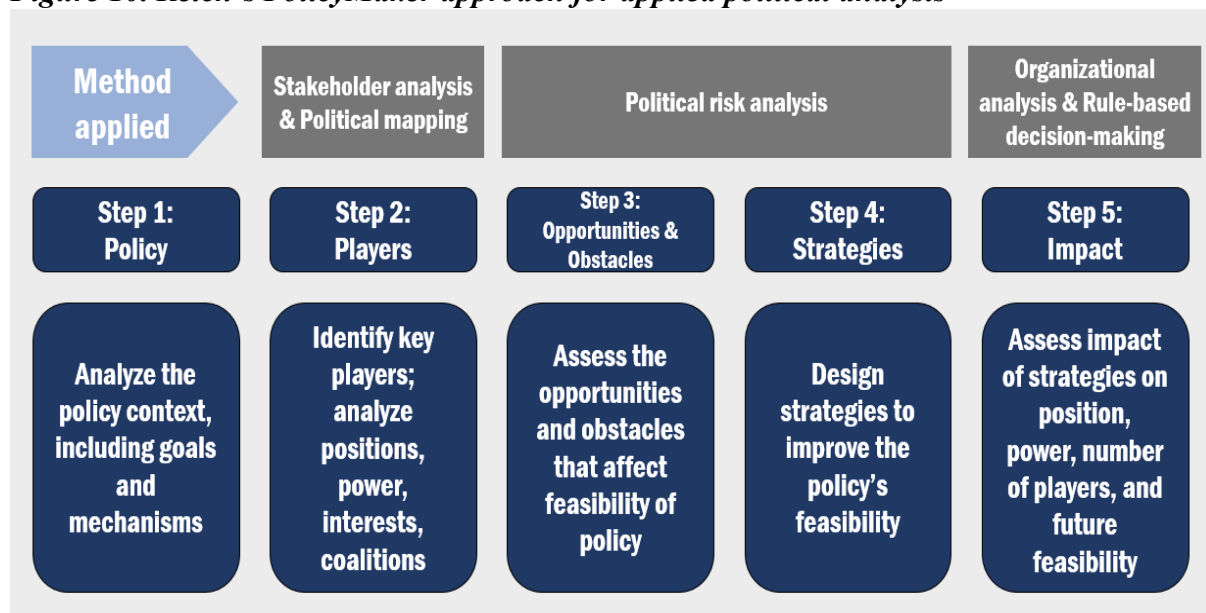
3.2 Methodology

3.2.1 Conceptual Framework

The primary conceptual framework for this analysis is based on Reich's approach to the political economy of health system reform, which 'seeks to identify systematic relationships between economic and political processes and the resulting impact on the distribution of resources' (Reich 1994, p414). Reich argues that there is a need for greater applied political analysis in public health, which typically emphasizes epidemiological and economic analysis in the process of policy development. He defines applied political analysis as 'assessment procedures to probe the political dimensions of policymaking, in ways that enhance the quality of reform processes' (Reich 1996, p2). It is important to emphasize the 'applied' element: for political analysis to be useful in improving the prospects of implementation, it must be rooted in practicality and feasibility, rather than a scholarly theoretical exercise.

Applied political analysis encompasses a variety of methodologies, such as stakeholder analysis, political mapping techniques, or analysis of veto points; with a goal of developing strategies to improve the possibility of successfully passing a reform. To provide a standardized, software-based platform for conducting applied political analysis, Reich developed the *PolicyMaker* tool, which has been applied in numerous contexts, from assessing the performance of national health reform in the Dominican Republic, to developing public policy lobbying strategies for a Fortune 500 company (Reich 1996b).

Figure 10. Reich’s *PolicyMaker* approach for applied political analysis



Source: Adapted from (Reich 1996b).

PolicyMaker assists decision-makers in analyzing and managing the politics of health reform, by guiding them through a framework for systematic political analysis (Glassman et al. 1999). Three analytical methods underpin the *PolicyMaker* approach: political mapping techniques (including stakeholder analysis); political risk analysis; and organizational analysis and a rule-based decision system (Reich 1996b). The tool entails a five-step process: establishing policy context; identifying players; assessing opportunities and obstacles; designing strategies to improve the policy’s feasibility; and assessing the impact of the strategies (Figure 10).

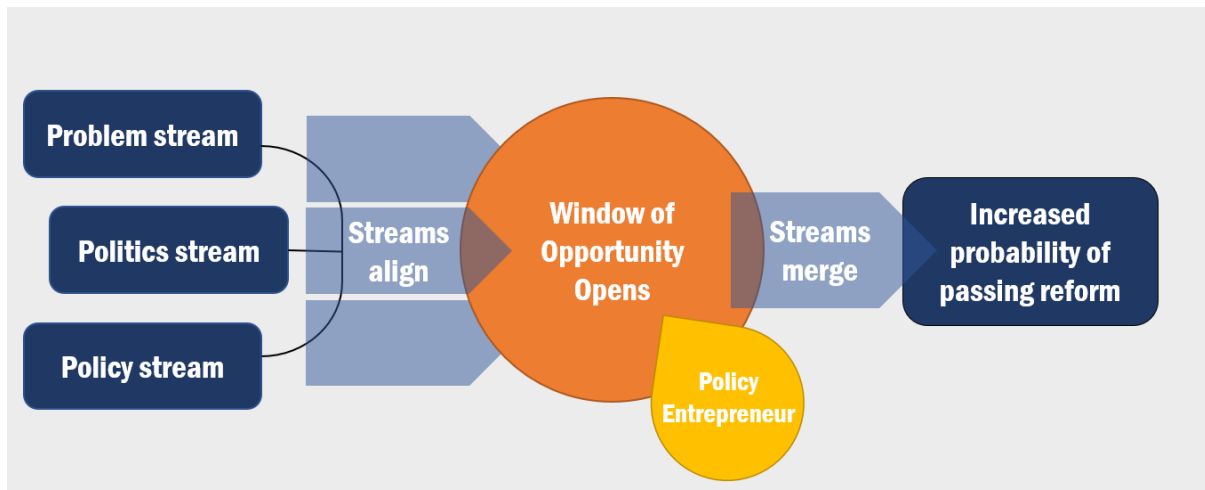
As this analysis applies a retrospective methodology, I primarily rely on the first three steps of the *PolicyMaker* process to frame the analysis and discussion. Although the emphasis of this stakeholder analysis is on actors external to the Malaysian government – such as healthcare provider associations, civil society, insurance companies, academics, and opposition parties – I also consider how these interests may have aligned or conflict with the interests of key players within the government.

Stakeholder analysis and political mapping present an optimal framework for a political analysis of 1Care. One of the most important and complex problems in designing health reforms is managing the short-term, concentrated costs incurred by powerful interest groups (Glassman et al. 1999). Stakeholder analysis attempts to understand the behavior, agendas, and interests of relevant actors to determine the degree to which they can influence the decision-making process (Varvasovszky and Brugha 2000). This methodology is well-suited to a retrospective analysis, in which stakeholders have revealed their positions and willingness to deploy resources, and the outcome of the reform has already been decided.

After using Reich's *PolicyMaker* approach to analyze stakeholders, their positions, and the barriers they put in place, I expand the analysis further by applying Kingdon's multiple streams framework (Figure 11). According to Kingdon, setting a policy agenda requires the merging of three streams: the problem stream, in which a national issue or persistent trouble arises; the policy stream, in which a solution is proposed to remedy the problem; and the political stream, in which a window of opportunity is presented (Kingdon 1995). Problems may arise from acute, tragic events such as natural disasters or mass shootings; or may represent chronic issues that have received long-term media attention and are felt and understood by all, such as crime or health care. Successfully setting the policy agenda requires the ability of a skilled policy entrepreneur, with the ability to recognize the window of opportunity when the problem and

political streams are aligned, and to promote the emergence and feasibility of a public policy (Ridde 2009).

Figure 11. Kingdon's multiple streams approach to agenda setting



Source: Adapted from (Kingdon 1995).

I explore how the interests and barriers of external stakeholders interacted with the political environment and the policy process, and the extent to which these factors ultimately contributed to blocking the reform. The multiple streams approach has been applied across a wide range of sectors, particularly in the field of global health policy, and incorporates the complex moving parts of the policy process, making it an appropriate framework for this analysis (Zahariadis 2014). Rather than focusing on a single explanatory variable, the framework considers the myriad interactions at play within the context of the policy environment.

Adopting the multiple streams approach provides a useful lens to complement the stakeholder analysis, since different stakeholders will act upon different streams. As this paper discusses at length, stakeholders have notably diverse interests, and hold very different forms of power, both 'hard' and 'soft'. A stakeholder's ability to block reform is predicated by its power, but this power must be applied to the appropriate stream. A Member of Parliament in the Economic

Council, for example, has vastly different resources at hand than a private GP in an affluent suburb; yet both may play an important role in derailing a policy.

3.2.2 Data

Qualitative data for this analysis were collected from documents in the peer-reviewed and grey literature on Malaysia's 1Care reform, as well as a general web-based search using Google and various social media platforms. Grey literature comprised documents, working papers, white papers, reports, and research outside of traditional peer-reviewed academic publishing; sources ranged from business and industry, to policy analysts and think tanks, to academic institutions. These data were supplemented with a series of in-depth, semi-structured interviews conducted by a research team under the Malaysia Health Systems Research (MHSR) project.

Documents

A large component of the data for this analysis was collected through a comprehensive desk review, beginning with a search of the peer-reviewed and grey literature on 1Care and health reform in Malaysia. Keywords for collecting materials included health care reform in Malaysia, '1Care for 1Malaysia', political economy of Malaysia, social health insurance, national health insurance, the names of specific stakeholders, combinations of the above, and other related search terms.

A general web-based search further resulted in a wide variety of source material on 1Care – such as newspaper articles, blogs, press statements, government publications, political party manifestos, newsletters, meeting notes, and conference presentations. Social media sites such as Twitter, Facebook, and YouTube – all of which were used by opponents of the reform to spread an anti-1Care campaign – were also included in the search.

The document search provided insight into stakeholders' power, positions, and willingness to deploy financial resources – such as an interest group funding a social media campaign against the reform, or a professional organization hosting a conference to discuss the policy. For example, a search on the Malaysian Medical Association (MMA), a key stakeholder, yielded information about the group's member size, leadership structure, relationship with the government, and affiliated organizations, all of which are an indication of its power. A radio interview with the MMA President about 1Care revealed the organization's position on the reform.

Interviews

The Malaysian Health Systems Research (MHSR) project is a collaboration between Harvard University and the Malaysian Ministry of Health. As part of the Political Economy and Institutional Analysis component of the MHSR project, a team of researchers conducted in-depth stakeholder interviews with an array of stakeholders with interest in, or influence over, health care reform in Malaysia. The Harvard team members comprised Kevin Croke, Amrit Kaur Virk, and Yadira Almodovar-Diaz. As a member of the MHSR team, I was granted access to the audio recordings and transcripts from the study. To preserve confidentiality, interviewees were numbered randomly.

The researchers addressed the following research question: why has comprehensive health system reform failed to be passed and adopted numerous times in Malaysia over the past 30 years, despite having been consistently on the health policy agenda since the early 1980s? (Croke, Virk, and Almodovar-Diaz 2015). The research team interviewed 42 key stakeholders, including current and former Ministry of Health officials, other ministry and executive agency officials, health providers (private sector physicians, public sector physicians, and hospital managers), NGOs, international organizations, and business leaders (2015). I recorded any

relevant information or observations from the interviews that could inform the stakeholder analysis.

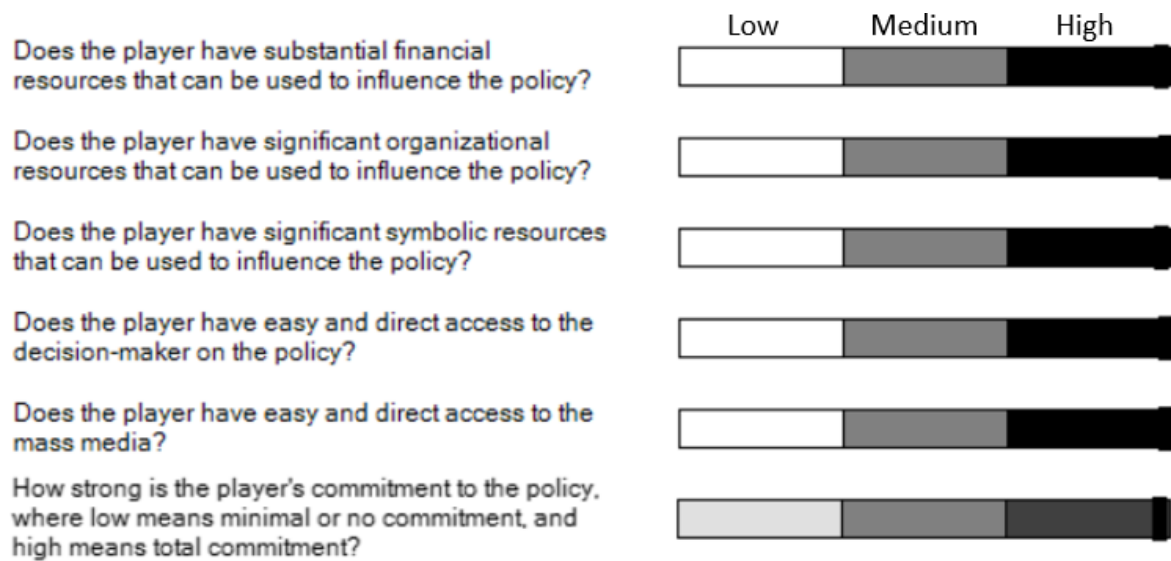
To supplement the findings from the document search, I conducted informal interviews with ten experts, including an academic who had written about 1Care; a physician working in a government hospital and one in a private hospital; and several policy analysts at research institutions. These discussions were not used as a primary source of developing hypotheses, but rather to provide additional context and confirm or refute findings from the literature and document review.

Analysis

The stakeholder analysis was conducted in three steps: identifying stakeholders affected by the 1Care reform; assessing stakeholders' resources, interests, and relationships; and evaluating the positions taken and roles played by each stakeholder in relation to the reform. Stakeholders (or players, in *PolicyMaker* terminology), were defined as any relevant groups or individuals that had an interest in, or were affected by, the 1Care reform.

Data collected from the document search and interviews were organized into a spreadsheet matrix, then entered into *PolicyMaker* using the tool's built-in analytical framework, which guides the user through each step of the process. The tool includes questionnaires to assess stakeholder position on the policy (support, opposition, or non-mobilized), their power (resources available to deploy), and their intensity of position (willingness to use resources for the policy debate) (Figure 12). To the extent possible, I considered both tangible resources, such as money and people, and intangible resources, such as an organization's legitimacy and access to key decision-makers, for the analysis (Roberts et al. 2003b).

Figure 12. PolicyMaker questions to assess stakeholder power and position



Source: Screenshot from PolicyMaker tool.

To assess the level of support or opposition for each stakeholder, simple criteria were developed to assign a rating of high, medium, low, or non-mobilized, based on the information found in the document search and interviews (Table 5). An example of an explicit statement, indicating high opposition to 1Care, includes the following declaration by the secretary general of the DAP opposition party: ‘the DAP calls for the Prime Minister Datuk Seri Najib Minister to intervene and scrap 1Care for 1Malaysia proposal’ (Lim 2012).

After data have been entered, the *PolicyMaker* software automatically produces results from the analysis. Using political mapping techniques, the players are displayed on a continuum from high support, to non-mobilized, to high opposition. *PolicyMaker* then presents the data in a political feasibility graph, using an algorithm to calculate feasibility based on three variables: power, intensity of position, and number of mobilized groups. The output from this analysis was then applied with Kingdon’s multiple streams framework to consider how and where the barriers set up by stakeholders were able to influence the policy process.

Table 5. Criteria for rating stakeholder position on 1Care policy

Rating	Criteria
High	<ul style="list-style-type: none"> ▪ Stakeholder explicitly states support or opposition to policy (or is a member of coalition making such statement) ▪ Stakeholder makes a clear call to uphold the policy (if support) or end the policy (if opposition) ▪ Stakeholder maintains a constant position on policy throughout ▪ Stakeholder uses significant resources (tangible and/or intangible) to support or oppose policy
Medium	<ul style="list-style-type: none"> ▪ Stakeholder explicitly states support or opposition to policy (or is a member of coalition making such statement) ▪ Stakeholder uses minimal resources to support or oppose policy
Low	<ul style="list-style-type: none"> ▪ Stakeholder supports or opposes policy in general but questions / calls for changes to specific elements of policy ▪ Stakeholder does not maintain a consistent position on policy or has internal divisions with regards to position on policy ▪ Stakeholder does not use resources to support or oppose policy
Non-mobilized	<ul style="list-style-type: none"> ▪ Stakeholder makes no clear statements or commitment to policy, either in support or opposition, based on data available ▪ Stakeholder is explicitly characterized as non-mobilized in literature review and/or interviews

3.3 1Care for 1Malaysia: A description and timeline of the reform

3.3.1 Policy description

The MOH described its vision for the reform in a 2009 concept paper entitled ‘1Care for 1Malaysia: Restructuring the Malaysian Health System’ (Ministry of Health, Malaysia 2009). This paper serves as the primary source document detailing the components of the reform; unless otherwise noted, all references to 1Care in this section draw from that source.

Under 1Care, the restructured national health system would be ‘responsive and provide choice of quality health care, ensuring universal coverage for the health care needs of the population based on the spirit of solidarity and equity’ (Ministry of Health, Malaysia 2009, p4). At its core, the policy proposed wholesale reform: a major transformation of the Malaysian health system, both in terms of financing, which would shift to contributions from mandatory social health insurance (SHI); and service delivery, which would be devolved to an autonomous body.

SHI is defined by three main characteristics: the nature of contribution is compulsory; eligibility is conferred only when a premium has been paid; and benefits and costs are specified in a social contract (Hsiao and Shaw 2007). As the name suggests, rather than being profit-driven, the goal of SHI is to maximize social benefits and promote equity. The principle of social health insurance is an exchange defined by law: enrollees pay a premium to receive a legal entitlement to a defined benefit package. The poor can be fully or partially subsidized by the government. Enrollment is mandatory to overcome the problem of adverse selection while pooling resources between the rich and poor, the healthy and less healthy, and the old and the young. Although enrollment is mandatory, citizens are eligible to receive benefits only after they have paid the required premium. Similar to private insurance, premiums are paid by consumers, but more closely reflect ability-to-pay as opposed to willingness-to-pay.

The fundamental difference between SHI and tax-financed systems is that the former raise revenues from wage-based contributions, which are earmarked for health; whereas the latter raise revenues through taxes and other government contributions, which are generally not earmarked for health. SHI systems are typically more likely to contract with providers, both public and private, whereas tax-financed systems often directly manage providers and do not provide a legal entitlement to a defined benefit package. In contrast to tax-based NHS models, social health insurance advocates argue that SHI provides an important additional source of revenue for the health system, and achieves a better quality of care at a lower cost (Wagstaff 2009). This is accomplished by separating the purchasing of health care from its provision and encouraging selective contracting between providers (including private sector ones).

At the time of 1Care's introduction, the Malaysian health system boasted numerous accomplishments. Life expectancy at birth had increased substantially between 1970 and 2009, from 62 to 72 years for men, and 66 to 76 years for women, in line with the WHO average for the Western Pacific Region (Noh 2011). In the same time span, infant mortality decreased from

39.4 to 6.4 deaths per 1,000 live births; and maternal mortality decreased from 1.4 to 0.3 deaths per 1,000 live births (Noh 2011).

Despite these accomplishments, the Malaysian healthcare system faced numerous challenges, beginning with the shift from a relatively equitable, accessible health system towards a two-tiered system fueled by for-profit insurers and providers. Total health expenditure was increasing steadily, from 2.8 percent of GDP in 1995 to 4.3 percent in 2009 (MNHA Unit 2017).⁷ However, in 2009, out-of-pocket spending remained a major source of financing for health, at 32.9 percent of total, second only to the government, which accounted for 56.7 percent of total health expenditure, while private health insurance comprised 6.5 percent (2017).

This heavy reliance on out-of-pocket spending, and the minimal role played by social security funds (namely the Employee Provident Fund and the SOCSO fund) to protect against catastrophic health expenditure, led the 1Care concept paper to conclude that Malaysia's health financing was more aligned with that of a lower-middle income country than a country striving for high-income status by 2020.

The 1Care concept paper outlined five key goals of the reform, and the mechanisms by which these goals would be achieved (Table 6). (See *Annex 2* for a graphic representation of the restructured health system proposed by 1Care.)

⁷ Note: For consistency, unless otherwise noted, all health expenditure figures cited in this document reference the latest MNHA publication: *Ministry of Health, Malaysia. (2017). Malaysia National Health Accounts: Health Expenditure Report 1997-2015.*

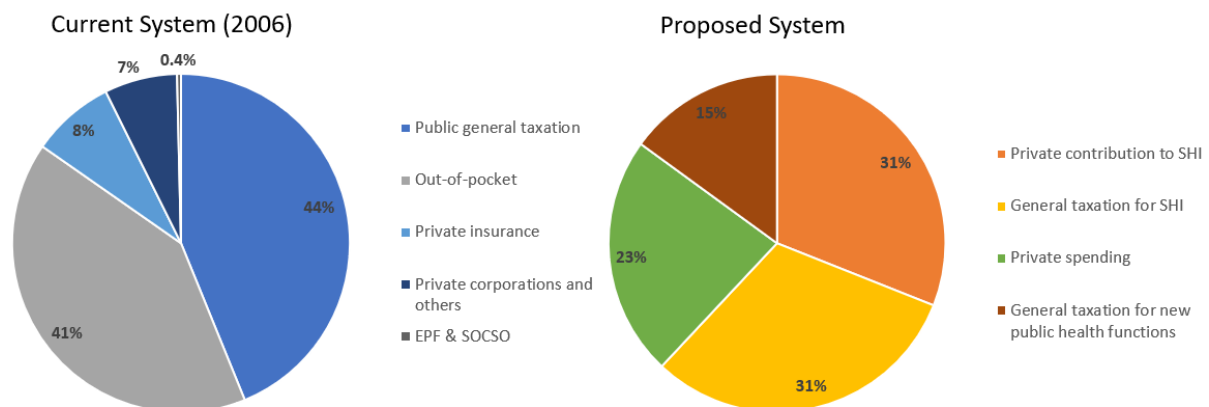
Table 6. Goals and Mechanisms of 1Care

Goal	Mechanisms
Universal health coverage for all Malaysians	<ul style="list-style-type: none"> ▪ Managed by autonomous statutory body accountable to MOH: National Health Financing Authority (NHFA) ▪ Mandatory, publicly administered national social health insurance (SHI) ▪ Premium contributions from employees and employers (community-rated, sliding scale) ▪ Contributions from general government revenue ▪ Minimal copayments for defined benefits package
An integrated health care delivery system with a thrust on primary health care	<ul style="list-style-type: none"> ▪ Managed by autonomous statutory body accountable to MOH: Malaysian Healthcare Delivery System (MHDS) ▪ Horizontal integration of public and private health care providers through standardized care pathways, performance tools ▪ Independent contracting of primary health care providers (PHCP) ▪ Vertical integration between levels of care via national registration and implementation of family doctor and gatekeeper referral system
Provision of affordable, efficient, and sustainable health care	<ul style="list-style-type: none"> ▪ Increased technical and allocational efficiency through risk pooling, standardized treatment protocols, drug lists and pricing ▪ Drug dispensing by pharmacies ▪ Prepayment and purchasing of health care services rather than fee-for-service reimbursement ▪ Purchasing by autonomous agency accountable to MHDS: Primary Health Care Trust (PHCT) ▪ Performance-based contracting with providers ▪ Emphasis on primary and preventive health care
An equitable health system in terms of both access and financing	<ul style="list-style-type: none"> ▪ Subsidized government SHI premiums and exempted co-payments for the poor, disabled, and elderly ▪ Establishment of effective safety nets for catastrophic spending ▪ Community-rated premiums based on a sliding scale with respect to income ▪ Standardized benefits package ▪ Access to both public and private care
A streamlined MOH focused on governance, stewardship, and public health services	<ul style="list-style-type: none"> ▪ Separation of regulator-purchaser-provider functions from MOH, through the creation of autonomous functions- NHFA, MHDS ▪ New Public Health Function, including policy development, regulatory body, M&E ▪ Overseeing community health services, communicable disease control

The rationale for 1Care was framed around a narrative of ‘solidarity’, ‘fairness’, and ‘equity’ – words repeated throughout the concept paper. The opening remarks of the paper state that 1Care is in line with Prime Minister Najib Tun Razak’s vision of 1Malaysia, which emphasizes ethnic harmony, national unity, and efficient governance. Whereas the paper acknowledges

Malaysia's success in achieving universal coverage, it contends that inequities remain, largely due to the imbalance between private and public sectors, and disparities between urban and rural populations. Restructuring the health system and automating service provision, the paper argues, would achieve greater technical and allocative efficiency; and performance-based initiatives would improve the quality of service delivery.

Figure 13. Change in sources of health financing under 1Care



Source: Adapted from 1Care Concept Paper (Ministry of Health, Malaysia 2009)

Under 1Care, sources of health financing would shift considerably, with the major contributions from SHI premiums and general taxation. Private spending would decrease significantly; out-of-pocket payment would be required only for minimal co-payments and services not covered under SHI. Although there would be no 'opt-out' feature for SHI, private health insurance could be purchased as a voluntary top-up for luxury services not covered under SHI. Furthermore, the concept paper estimated that total health expenditure would increase from an 4.7 percent of GDP in 2007 to 6.2 percent of GDP, whereas the government subsidy for health would decrease from 17.9 percent of total health expenditure in 2007 to 15.6 percent

under 1Care.⁸ Table 7 summarizes the key departures from the status quo proposed by the 1Care policy.

Table 7. Comparison of current system to 1Care proposal

	Current System	Under 1Care
Financing	<ul style="list-style-type: none"> ▪ General tax funding for public health system ▪ Private health services paid out-of-pocket or through private insurance ▪ Nominal registration fee (RM1 or RM5) 	<ul style="list-style-type: none"> ▪ Mandatory SHI enrollment at a fixed premium (contribution from employer and employee, govt) (rate unspecified) ▪ General tax funding for new public services ▪ OOP and PHI for top-up ▪ Co-payments (rate unspecified)
Delivery	<ul style="list-style-type: none"> ▪ Two-tiered public and private system ▪ Private wards in some public hospitals (FPP) 	<ul style="list-style-type: none"> ▪ Horizontal integration of public and private providers ▪ Vertical integration between levels of care with family doctor gatekeeper system
Purchasing	<ul style="list-style-type: none"> ▪ No separation of purchasing and provision function in public ▪ Private health insurers and MCOs purchase from private sector 	<ul style="list-style-type: none"> ▪ Separation of regulator-purchaser-provider functions, creation of autonomous NHFA, MHDS ▪ Strategic purchasing of standard benefits package
Dispensing and prescription	<ul style="list-style-type: none"> ▪ Separated at government and private hospitals ▪ GPs and small clinics provide both functions 	<ul style="list-style-type: none"> ▪ Separate at all levels; only pharmacists will be able to dispense drugs
Referral system	<ul style="list-style-type: none"> ▪ Government hospitals require referral letter for specialists ▪ Private hospitals have no requirements other than ability to pay 	<ul style="list-style-type: none"> ▪ Family doctor serves as gatekeeper referral system
Supply-side control	<ul style="list-style-type: none"> ▪ Public sector - none (fee-for-service) ▪ Private sector – some control by insurers / MCOs 	<ul style="list-style-type: none"> ▪ Provider payment mechanisms – capitation, DRGs
Demand-side control	<ul style="list-style-type: none"> ▪ Public – referral system ▪ Private – coverage limits, caps, by insurers / MCOs 	<ul style="list-style-type: none"> ▪ Co-payments ▪ Gatekeeper system

Source: Adapted from (Por 2011)

⁸ Note: estimates for Total Health Expenditure have been revised significantly since the publishing of the 1Care concept paper in 2009; figures released by the MNHA in 2017 estimate THE as 3.9% of GDP in 2007.

The 1Care concept paper laid out the reform in broad strokes; but details of the reform were considerably lacking. As stated in the document, the purpose of the concept paper was to seek input from the Prime Minister’s Economic Council, and to gain approval to develop a detailed blueprint for the restructured national health system within a two-year timeframe. However, the detailed blueprint was never formulated; in fact, referring to the ‘1Care policy’ is something of a misnomer, as the development of a full policy never came to fruition, and no health care reform bill was ever submitted to Parliament. The concept paper itself is only forty pages long; about half of which length is devoted to describing the reform.

It is important to note which details were not prescribed in the 1Care concept paper, as this provided ample room for opponents of the reform to spread misinformation about the policy. One of the most critical details was the quantum for the mandatory SHI contribution. Based on current utilization patterns, the concept paper estimated that the SHI premiums would cost 9.5 percent of average household income, and described two potential funding options, whereby employers and employees would either split the premium in half, or the employer would pay two thirds and the employee the remaining third. However, the contribution was not finalized, and the paper includes a clear disclaimer that the figures are preliminary estimates and would need to be recalculated with the development of a detailed policy.

The concept paper states a government commitment to fund SHI contributions for vulnerable population groups – the poor, disabled, and elderly – as well as government pensioners and civil servants. Qualification criteria for these vulnerable groups were not specified, although population figures and government spending on these groups were included in the paper. The number of poor to be subsidized by the government was indicated as 187,172; yet hardcore poor were estimated to account for 3.8 percent of the population in 2009, which would amount

to more than one million people. Furthermore the mechanism for collecting premiums, particularly from the informal sector, was not discussed.

There were several other important omissions. The concept paper called for ‘minimal’ co-payments at the point of care, but once again did not specify the amount, nor which services would require the payment, giving only examples such as ‘for dispensing of drugs and dental treatment within the SHI benefits package, and for services not covered by SHI’.

Financing medical services by capitation, with performance-based top-ups, was mentioned one time, without further detail on how the payments would be calculated and what proportion would be given as top-ups. The paper described the need for a standardized benefits package, but without indicating the services and number of annual visits covered; although it did include statistics from the 1996 NHMS survey that estimated 6 annual primary care visits per person, 0.78 specialist clinic visits, and a 0.09 utilization rate for inpatient care. The utilization assumptions were used to calculate the annual cost of the health care system, and in turn, the estimated cost of the SHI premium.

Another controversial aspect of 1Care was its approach to restructuring the MOH and its functions through the formation of three new agencies: the National Health Financing Authority (NHFA), the Malaysian Healthcare Delivery System (MHDS), and the Primary Health Care Trust (PHCT). Patient care would be devolved under the autonomous MHDS, which would remain under the MOH; the PHCT would be an autonomous agency accountable to the MHDS. The NHFA would be an autonomous statutory body, non-privatized and accountable to the MOH. Critics decried the potential for patronage, and, after the 1MDB corruption scandal, were concerned about yet another government-linked agency handling a large fund paid into by the hardworking *rakyat*.

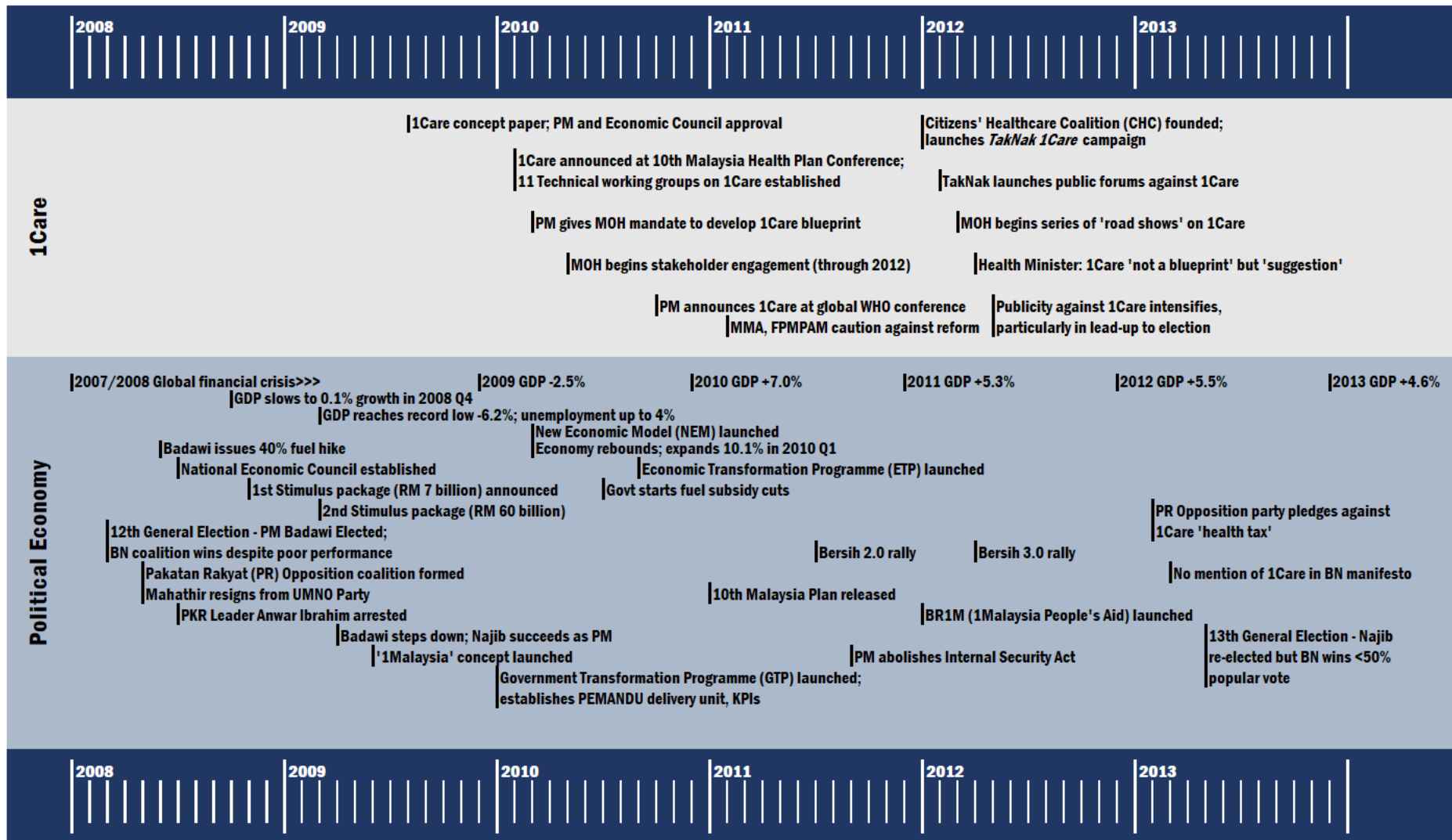
3.3.2 Timeline of 1Care

Timing is a critical element to successfully setting health care reform on the political agenda (Fox and Reich 2013). 1Care was introduced after the 12th general election in 2008, and scrapped prior to the following election in 2013; these two political events serve as useful points of demarcation to analyze the reform (Figure 14).

Dubbed a ‘political tsunami’, the 2008 election marked the worst performance to date for the ruling Barisan Nasional (BN) coalition, winning just 51 percent of the popular vote, and 63 percent of parliamentary seats (*The Economist* 2008). For the first time, BN lost the two-thirds majority in parliament needed to amend the constitution. Prime Minister Ahmad Badawi, shouldering much of the blame for his party’s poor showing, stepped down shortly thereafter, paving the way for his deputy Najib Razak to ascend to the PM position in April 2009.

PM Najib inherited the daunting prospect of steering the country through a major recession. Spurred by the 2007/2008 global financial crisis, the economic downturn saw plummeting exports, slowed growth, and rising unemployment, as key sectors such as palm oil, rubber, oil and natural gas were hit by falling commodity prices. As deputy PM, Najib had introduced two ambitious stimulus packages in 2008 and 2009 which, combined, amounted to 10 percent of GDP. The stimulus complemented efforts by Bank Negara Malaysia such as cutting policy interest rates to support the economy. To mark his 100th day in office, PM Najib also introduced a series of economic ‘sweeteners’ such as cuts in road toll charges and business license fees.

Figure 14. Timeline of 1Care



As the economy began to rebound in 2010, PM Najib unveiled his New Economic Model (NEM), a plan to more than double per capita income and reach high-income status by 2020; and the Economic Transformation Programme (ETP), a blueprint to achieve this goal. Replacing the controversial New Economic Policy (NEP), the plan introduced gradual reforms to liberalize the economy and reduce the government's policy of preferential treatment for the Bumiputra. In a bid to encourage foreign investment, for example, the requirement for companies in the services sector to offer a 30 percent stake to Bumiputra investors was eliminated.

Meanwhile, the three major opposition parties – PKR, DAP, and PAS, which had won 41, 73, and 86 seats, respectively, in the 2008 elections – officially formed the Pakatan Rakyat (PR) coalition. The NEM was panned by PR leaders as devoid of substance and a publicity tool for BN. Despite relaxing pro-Bumiputra economic policies, PM Najib's subsequent launching of a special unit to strengthen the Bumiputra economic agenda was viewed as flip-flopping and a tacit continuation of the affirmative action policies set out by NEP (*The Star Online* 2011).

On the health policy front, the National Health Financing (NHF) unit, under the Planning Division of the MOH, was drafting the 1Care concept paper, which was presented before the PM Najib and his Economic Council and then Cabinet in August 2009. There was agreement in principle with the concept, with the PM requesting the NHF carry out three activities: make projections of health spending under 1Care; assess the policy's impact on all sectors; and begin engaging stakeholders (Croke, Virk, and Almodovar-Diaz 2015).

The first public announcement of 1Care occurred in conjunction with the presentation of the 10th Malaysia National Health Plan, at an eponymous conference in February 2010. This conference also initiated the creation of eleven Technical Working Groups (TWGs) on 1Care, which comprised government divisions, agencies, and external stakeholders, and considered

issues such as service delivery, governance and financing, human capital and information technology. The PM mandated the MOH to develop a detailed blueprint for 1Care within the next two years.

In October 2010, the PM announced Malaysia's 1Care reform in an address to the 66th session of the World Health Organization Regional Committee for the Western Pacific. Echoing the concept paper, he described 1Care's goal of creating a responsive health system which would emphasize quality and universal coverage based on solidarity and equity. Addressing why there was a need to change a 'good model' of health care, PM Najib stated: 'The reason is simple enough. We want to do better. Like other countries in the world, Malaysia has to grapple with challenges brought about by the epidemiologic and demographic transitions, overall health care cost escalation, increasing out-of-pocket spending, overstretched public facilities and increasing client expectations' (Razak 2010). The PM also emphasized that the government would maintain its role in providing a strong safety net for the population.

With the introduction of 1Care in the 2010 Malaysia Health Plan, and as discussions with the technical working groups were under way, news outlets increasingly began to publish articles about 1Care. As few details were available, the media initially quoted PM Najib's description of 1Care as 'a more efficient and effective system in ensuring universal access to health care' (*Malaysiakini* 2010b).

Some of the earliest skepticism to the reform began in 2011 from professional provider associations, such as the Malaysian Medical Association (MMA) and the Federation of Private Medical Practitioners' Associations Malaysia (FPMPAM). A lengthy editorial by the MMA President denounced 'slogans such as 1Care' as 'nebulous and unclear, and not convincing enough to encourage acceptance by our citizens, and certainly in the current form, not by the medical profession' (Quek 2011).

The President of FPMPAM decried the policy as a ‘huge profit-driven monster that will be impossible to control as the regulator will also be an operator of the industry via its GLC’ (Chow 2011). Opinion pieces against 1Care – primarily written by members of FPMPAM and similar organizations – began to appear in several mainstream news outlets. Early attempts by the MOH to counteract these accusations – such as the Director General’s plea to ‘give us a chance’ to demonstrate 1Care would ‘invite more collaborative efforts in win-win partnerships between the government, the *rakyat*,⁹ the economy, and all health providers’ – mostly fell on deaf ears (Abdul Rahman 2011).

With the contents of the 1Care concept paper made public, the backlash against the reform intensified throughout 2011 and 2012. This culminated with the *TakNak 1Care!* (‘Say No to 1Care!’) social media campaign, funded by the newly formed Citizens’ Healthcare Coalition (CHC). The coalition of 17 NGOs, spearheaded by FPMPAM and an MP from the People’s Justice Party (PKR), demanded the government shelve the 1Care proposal, warning that its implementation would spell disaster for the health system (*Malaysian Insider* 2012).

In addition to hosting a small number of public forums, the CHC mounted the TakNak campaign across multiple social media platforms, making liberal use of sensationalist headlines (such as “Your money or your life?”), and manipulating figures from the concept paper to spread misinformation about the policy. Against a backdrop of ominous music and animations of dripping blood, YouTube videos stated that SHI would force individuals to pay 10 percent of monthly income for premiums – neglecting to mention the government and employer contributions – which would only cover visits to the GP (*see Annex 3 for sample clippings from the campaign*). The campaign claimed that all services would be charged at private sector rates, causing costs to skyrocket, which would ultimately be paid for by the people. Elements of truth

⁹ Appealing to the ‘*rakyat*’, or ‘citizens’, is an oft-used rallying cry in Malaysian politics.

were also portrayed in a negative light, vilifying the compulsory nature of the contribution as robbing the public of the freedom to choose, and forcing people to pay more for less.

Whereas the most vocal resistance came from the CHC coalition, which was formed explicitly in response to 1Care, other stakeholders opposed or expressed concerns about the reform. The Coalition Against Health Care Privatisation (CAHCP), a grouping of academics and civil society, rejected 1Care and called instead for a pull-back from privatization, an increase in the government health budget, and improved conditions and pay for health care workers. A grouping of GPs and primary care providers, the Primary Care Providers' Coalition (PCPC), raised concerns over the implementation of capitation payment, the provision of dispensing separation in the 1Care plan, and the increased regulation and monitoring that would be required under the reform.

Meanwhile, trouble was brewing for PM Najib and Barisan Nasional in the lead-up to the 13th general election, termed a 'gamechanger' and 'the mother of all elections' (Nawab 2014). Amid perceptions of corruption, BN's approval rating had reached a record low of 45 percent, while the PR opposition coalition was on an upward trajectory since winning five of thirteen state elections, and almost half of the popular vote, in the previous election (Nehru and Tran 2013).

PR capitalized on the negative public opinion surrounding BN. The opposition's alternative election manifesto entitled 'The People's Pact, the People's Hope' promised to address economic disparities, curb corrupt practices, establish institutional reforms, and support the country's diverse cultures. In addition to pledging 'free access to basic health care for all,' the manifesto rejected 'all attempts to introduce a healthcare tax such as 1Care' (Pakatan Rakyat 2013).

The Najib administration faced even greater pressure from civil society. In July 2011, up to 50,000 Malaysians marched in the Bersih 2.0 rally, organized by the Coalition for Clean and

Fair Elections, and endorsed by the opposition coalition and 62 NGOs demanding an end to electoral fraud (*Malaysiakini* 2011). Bersih 3.0, the subsequent rally in April 2012, drew an even greater turnout; with upward estimates at 300,000 people, the rally marked the largest democratic protest in Malaysia's history (*Malaysiakini* 2012b). In addition to the primary objective of electoral reform, Bersih organizers cited a host of concerns, including the environment, religious rights, and corruption; opposition to the 1Care health insurance scheme was also briefly mentioned in the movement's platform (Welsh 2012).

In an attempt to rally support for 1Care, the MOH published several rebuttals and editorials to clarify misinformation surrounding the proposal, and in March 2012 hosted a series of public 'road shows' on 1Care (*Malaysiakini* 2012a). The Minister of Health refuted claims that 1Care was in the final stages of development, emphasizing that the concept paper was not a 'blueprint' but only a 'suggestion' to improve the health system; a move that media outlets perceived as 'damage control' and 'backpedaling' (*The Star Online* 2012; Usit 2012).

As the general election neared, the MOH maintained its stance that 1Care was still in the early conceptual phase. Within the government, political support for the reform was waning: in the opinion of one interviewee, 1Care came to be viewed as 'a dirty word' that should no longer be publicly discussed (MHSR Interview #3). Although the PM had made early announcements about 1Care in 2010 following the concept's approval by Cabinet, two years later, the highest levels of government remained silent on the health care reform.

BN's election manifesto made no explicit mention of the policy, and adopted only a vague commitment to develop 'a national system that will provide every Malaysian with access to quality healthcare' (Barisan Nasional 2013). Health care reform was not high on the list of issues for the upcoming election – as always, economic woes, accusations of government corruption, and tensions between religious and ethnic groups took precedence.

There was no official death knell for 1Care made to the public; the policy was no longer openly pursued by the MOH, although opposition parties would rehash the 1Care debacle whenever it was politically expedient. Mentions of 1Care resurfaced in 2017, when the Minister of Health announced the creation of a government-linked, non-profit voluntary health insurance, as described in Part II of this Results Statement.

Ultimately, the 2013 elections were a setback for both the ruling BN and the opposition PR coalitions. Despite winning the popular vote by a slim margin, PR failed to take the election, and BN lost even more parliamentary seats, reducing its majority to only 28 seats in a 222-seat parliament (Nawab 2014). The election marked a watershed moment in Malaysian politics. For the first time since independence, BN had lost the popular vote; and the presence of a two-party system as a permanent fixture was established (Nehru and Tran 2013). The ruling coalition's loss of seats in Sabah and Sarawak – predominantly rural states that had long been bulwarks for BN – established East Malaysia as a force to be reckoned with, and a 'kingmaker' for the next political cycle (Nawab 2014).

3.4 Stakeholder analysis

Historically, interest groups in Malaysia have sought to channel their influence directly through the executive branch of government, rather than by way of public assembly (Por 2011). Whereas Malaysia is democratic in terms of constitutional structure, it has tended to use an authoritarian approach – what has been labeled a 'repressive-responsive regime' – to enforce policy changes, and control social divisions and political tensions (Crouch 1996). This remains largely the case today, even in the face of growing discontent expressed by the public and civil society groups.

A prime example of this repression is the 1948 Sedition Act, a law banning any act, speech, or publication that brings contempt against the government and prohibits questioning the special

position of the ethnic Malay majority and the natives of Sabah and Sarawak. The law has not only been used against opposition politicians – including PKR leader Anwar Ibrahim – but also journalists, students, and academics (Pak 2014). Despite the PM’s earlier promises to repeal it, the Act was amended in 2015 to expand the ban to cover online media, a move criticized by Amnesty International and the United Nations as an attack on freedom and human rights (Saddique 2015).

As described in Section 2.4.1 of the Analytical Platform, the Prime Minister and Cabinet hold considerable authority over the legislative and judiciary branches of government. With UMNO the dominant force within BN and the Cabinet, the locus of veto power resides with the PM and his party leadership; policy changes favored by UMNO are therefore highly likely to be approved by the Cabinet and subsequently the Parliament (MacIntyre 2001). Enjoying a vast majority in Parliament since the country’s independence until 2008, BN did not seek consultation by nature when formulating policy.

After the 2008 elections, the rising power of the political opposition and loss of Barisan Nasional’s two-thirds parliamentary majority presented the first signs of weakness in its seemingly impenetrable armor. There were other important changes that had an impact on the ability of interest groups to influence health policy: notably, the increasing pluralism of the health sector, and the emerging role of the state as an investor in the healthcare market, in addition to its existing dual role as provider and regulator. Although the ruling coalition firmly retained its power to dictate policy, its losses in the 2008 elections were a major setback and made BN wary of taking on political risks that could jeopardize the outcome of the next election. These changes provided some added leeway for stakeholders to exert their influence, although stakeholder opposition alone would still not be enough to overcome the decisive veto power retained by the PM and his Cabinet.

This observation leads to a pivotal question: was the fundamental cause of 1Care's failure a result of strong stakeholder opposition, or ultimately due to a lack of support by the ruling coalition? To gain insight into this question, an in-depth analysis of the interests and power of both government players and external stakeholders is required.

3.4.1 Overview of stakeholders, power, interest, and position

Stakeholder analysis combines interest group analysis, which looks at social groups seeking to press the government in a particular direction; and bureaucratic politics, which focuses on competition amongst and within agencies inside the government (Roberts et al. 2003b). Stakeholders relevant to health sector reform include players both outside government and those inside government.

For this analysis, stakeholders were first grouped by their position in relation to the government and ruling coalition. Stakeholders inside the government comprised the Prime Minister, Minister of Health, National Health Financing Unit, Ministry of Finance, relevant economic agencies (Central Bank, Economic Planning Unit, PEMANDU), and the political parties that make up the ruling BN coalition. External stakeholders included opposition political parties, professional associations, non-governmental organizations and civil society, industry, academia, and health policy-related stakeholder coalitions.

Table 8 details the stakeholders and coalitions included in this analysis; their functions and sources of power; their interests; and the impact 1Care would have on these interests. These stakeholders are discussed in greater detail in the subsequent sections of this chapter: Section 3.4.2, focusing on the stakeholders' interests; Section 3.4.3, assessing the stakeholder coalitions that mobilized against 1Care; and Section 3.4.4, discussing the stakeholders' power and whether it was wielded effectively to promote their position on the reform.

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
Ministry of Finance	Ministry of Finance	<ul style="list-style-type: none"> ▪ Develop national economic policy, prepare federal budget ▪ Oversees financial legislation and regulation ▪ Led by Prime Minister 	<ul style="list-style-type: none"> ▪ Political – aligned with PM as head of MOF ▪ Bureaucratic ▪ Opposed to increasing health budget allocation 	<ul style="list-style-type: none"> ▪ Low support / non-mobilized ▪ In line with PM, initial support to 1Care but later did not hold a strong position on reform
Bank Negara Malaysia (BNM)	Central Bank of Malaysia	<ul style="list-style-type: none"> ▪ Issues currency; regulates financial institutions; develops credit system and monetary policy; advises Govt on economic policy and debt management ▪ Governor heads all financial institutions in Malaysia ▪ Decision-making, economic, institutional power ▪ Do not play direct role on health policy decision-making but advise on fiscal stability of proposed policies 	<ul style="list-style-type: none"> ▪ Ideological – conservative fiscal policy; interest in maintaining fiscal stability ▪ Consumer protection – regulations to protect consumers 	<ul style="list-style-type: none"> ▪ Non-mobilized ▪ BNM does not take a position on health policy but advises on financial sustainability
Economic Planning Unit (EPU)	Primary unit for development planning	<ul style="list-style-type: none"> ▪ Agency in Prime Minister’s Department ▪ Responsible for preparation of national development plans (i.e. 5-year plans) and long-term plans (i.e. Vision 2020); oversees implementation of plans ▪ Secretariat for Economic Council ▪ Key driver of earlier health privatization reforms 	<ul style="list-style-type: none"> ▪ Maintaining position as dominant role player in healthcare policy decision-making 	<ul style="list-style-type: none"> ▪ Low support / non-mobilized ▪ Economic Council initially approved 1Care concept but did not hold a strong position on the reform
Perf Mgmt and Delivery Unit PEMANDU	Results monitoring unit	<ul style="list-style-type: none"> ▪ Agency in Prime Minister’s Department ▪ Created 2009 as part of Econ. Transformation Prog (ETP) to achieve high-income status by 2020 ▪ Monitors ministries’ performance against key performance indicators (KPIs), sets priorities for govt agencies 	<ul style="list-style-type: none"> ▪ Bureaucratic - maintaining influence with Prime Minister, achieving results via KPIs ▪ ETP promotes private sector as engine for economic growth 	<ul style="list-style-type: none"> ▪ Non-mobilized ▪ Participated in facilitation of Technical Working Groups
Malaysian Medical Council (MMC)	Core regulatory body of medical profession	<ul style="list-style-type: none"> ▪ Government body with jurisdiction over both public and private sector; registers medical practitioners, enforces standards, makes policy decisions ▪ Access to high-level decision makers (President is DG of Health) ▪ Institutional power 	<ul style="list-style-type: none"> ▪ Organizational – may take on new oversight of functions under 1Care ▪ Public – protect consumers from malpractice, negligence 	<ul style="list-style-type: none"> ▪ Non-mobilized ▪ But MMC expressed support for reform; president is the DG of Health, who actively supported 1Care
Government-linked Investment Companies (GLICs)	Companies with control over GLCs	<ul style="list-style-type: none"> ▪ Companies with control over GLCs (majority shareholder, ability to exercise and influence major decisions); includes airports, airlines, telecom, finance ▪ 7 GLICs in total, including Khazanah and MoF Incorporated ▪ Manage hundreds of GLCs with assets equal to ~42% of the stock market, major shareholder in private healthcare 	<ul style="list-style-type: none"> ▪ Political – controlled by government ▪ Financial – major shareholder of companies across all industries; large stake in ownership of private healthcare sector 	<ul style="list-style-type: none"> ▪ Non-mobilized

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care (Continued)

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
Government-linked Companies (GLCs)	Companies with commercial objective, under GLICs	<ul style="list-style-type: none"> ▪ Represent hundreds of companies, play dominant role in almost all sectors ▪ Employ ~5% of national workforce; accounts for ~42% of stock market capitalization ▪ Over 40% of private hospital beds are controlled by GLCs; numerous insurers 	<ul style="list-style-type: none"> ▪ Financial – represent all industries and sectors across Malaysia; large stake in ownership of private healthcare sector 	<ul style="list-style-type: none"> ▪ Non-mobilized
Civil Services Union - CUEPACS	National union for civil servants	<ul style="list-style-type: none"> ▪ Represents approximately 1.2 million civil servants; massive bargaining power ▪ Negotiate working conditions, salaries and allowances with Public Services Department (JPA) 	<ul style="list-style-type: none"> ▪ Financial – promote financial interests of civil servants ▪ Promote union membership ▪ Offers CUEPACS Care health insurance scheme 	<ul style="list-style-type: none"> ▪ Concern over any policy that would increase costs for civil servants and confer benefits to civil servants that would render the union less relevant
Civil servants	Civil servants	<ul style="list-style-type: none"> ▪ Approximately 1.6 million civil servants, including military, police, health, and education 	<ul style="list-style-type: none"> ▪ Financial – improve their remuneration, working conditions, government benefits ▪ Provider choice and quality – want access to private care 	<ul style="list-style-type: none"> ▪ Govt would subsidize 1Care premiums for civil servants + 5 dependents + pensioners
Political parties in ruling coalition				
Barisan Nasional (BN)	Ruling coalition	<ul style="list-style-type: none"> ▪ Ruling coalition since Malaysian independence; comprises 13 parties ▪ 137 of 222 parliamentary seats (62%) ▪ Decision-making, compulsory, economic, structural, institutional power ▪ Strong record of economic performance - GDP growth averaged 6.4% per year between 1961 and 2011 ▪ Several state governments (Sabah, Melaka, Johor) have significant health care investments through corporate arm 	<ul style="list-style-type: none"> ▪ Political – win re-election; improve position and gain more seats and share of popular vote in 2013 election ▪ Ideological – promotes social conservatism ▪ Financial – considerable investment in private sector 	<ul style="list-style-type: none"> ▪ Low support / Non-mobilized ▪ Although 1Care received initial support from PM, in lead-up to election BN stepped away from health reform, did not include 1Care in 2013 election manifesto
United Malays National Organisation (UMNO)	Party in ruling coalition	<ul style="list-style-type: none"> ▪ Leading party within BN coalition (78 seats) ▪ Founding member of BN, party of Prime Minister ▪ Primarily represents ethnic Malay and Muslim constituency ▪ Membership: ~3.6 million 	<ul style="list-style-type: none"> ▪ Political – win re-election; maintain primary position within BN coalition ▪ Ideological – promotes social conservatism, ethnic Malay interests 	<ul style="list-style-type: none"> ▪ Non-mobilized (in line with BN)

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care (Continued)

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
Malaysian Chinese Association (MCA)	Party in ruling coalition	<ul style="list-style-type: none"> ▪ Second party within BN coalition (15 seats) ▪ Primarily represents ethnic Chinese constituency ▪ Ownership of two major newspapers, i.e. The Star (most widely read) ▪ Membership: ~1 million (but note many voted for opposition in 2008); competes with opposition DAP 	<ul style="list-style-type: none"> ▪ Political – win re-election; gain seats, improve position and influence within BN ▪ Ideological – promotes social conservatism, ethnic Chinese interests 	<ul style="list-style-type: none"> ▪ Non-mobilized (in line with BN)
United Bumiputra Heritage Party (PBB)	Party in ruling coalition	<ul style="list-style-type: none"> ▪ Third party within BN coalition (14 seats) ▪ Represents Bumiputra from Sarawak state (East Malaysia) ▪ Membership: ~300,000 	<ul style="list-style-type: none"> ▪ Political – win re-election; gain seats, improve position and influence within BN ▪ Ideological – promotes social conservatism, Bumiputra interests 	<ul style="list-style-type: none"> ▪ Non-mobilized (in line with BN)
Malaysian Indian Congress (MIC)	Party in ruling coalition	<ul style="list-style-type: none"> ▪ Minority party within BN coalition (5 seats) ▪ Largest political party primarily representing ethnic Indian constituency ▪ Membership: ~600,000 	<ul style="list-style-type: none"> ▪ Political – win re-election; gain seats, improve position and influence within BN ▪ Ideological – promotes social conservatism, ethnic Indian interests 	<ul style="list-style-type: none"> ▪ Non-mobilized (in line with BN)
EXTERNAL STAKEHOLDERS				
Political Parties in opposition				
Pakatan Rakyat (PR)	Opposition coalition	<ul style="list-style-type: none"> ▪ Opposition coalition; left-leaning / centrist parties (PKR, DAP, PAS) ▪ 76 of 222 parliamentary seats (34%); won 47% of popular vote in 2008 	<ul style="list-style-type: none"> ▪ Political – win election, gain more seats and share of popular vote in 2013 election ▪ Ideological – promotes social liberalism 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Oppose major reforms proposed by BN to gain political advantage ▪ Anti-1Care election manifesto
People's Justice Party (PKR)	Opposition party (part of PR)	<ul style="list-style-type: none"> ▪ Led by Anwar Ibrahim, former Deputy Prime Minister and Finance Minister ▪ Considered leading party within PR coalition despite fewer seats (23 seats) ▪ Centrist multi-racial party; major support from wealthy urban states i.e. Selangor, Penang ▪ Membership: ~150,000 	<ul style="list-style-type: none"> ▪ Political – win election; gain seats and influence within PR ▪ Ideological – centrist, social liberalism 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Oppose major reforms proposed by BN to gain political advantage ▪ Anti-1Care election manifesto

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care (Continued)

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
Democratic Action Party (DAP)	Opposition party (part of PR)	<ul style="list-style-type: none"> ▪ Second largest political party in Malaysia after UMNO (29 seats) ▪ Support from major cities, secular liberals, professionals, middle-class ▪ Support from ethnic Chinese community (many migrated from MCA) ▪ Membership: ~450,000 	<ul style="list-style-type: none"> ▪ Political – win election; gain seats and influence within PR ▪ Ideological – progressive social democracy, secularism 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Oppose major reforms proposed by BN to gain political advantage ▪ Anti-1Care election manifesto
Pan-Malaysian Islamic Party (PAS)	Opposition party (part of PR)	<ul style="list-style-type: none"> ▪ Major Islamic political party in Malaysia (23 seats) ▪ Electoral base primarily in rural and conservative areas ▪ Membership: ~800,000 	<ul style="list-style-type: none"> ▪ Political – win election; gain seats and influence within PR ▪ Ideological – social conservatism, Islamism 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Oppose major reforms proposed by BN to gain political advantage ▪ Anti-1Care election manifesto
Socialist Party of Malaysia (PSM)	Socialist party	<ul style="list-style-type: none"> ▪ Only socialist party with representation in Parliament (1 seat) ▪ Ran on PR coalition ticket for 2008 election ▪ Support from urban poor, industrial workers, plantation workers 	<ul style="list-style-type: none"> ▪ Political – win election; gain seats and influence ▪ Ideology – socialism, secularism 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Oppose major reforms proposed by BN to gain political advantage ▪ Also oppose on ideological grounds (align with CAHCP)
Professional Associations				
Malaysian Medical Association (MMA)	Primary representative body/NGO for registered medical practitioners	<ul style="list-style-type: none"> ▪ Largest representative body/NGO for physicians; state and national branches; includes public and private, GPs and specialists; ~14,000 members ▪ Strong political influence: close linkage with high-level MOH decision-makers; consulted on health policy; elects members to MMC, govt boards ▪ Financially strong, self-funded, owns properties, members from societal elites ▪ Widely influential – MMA-established fee schedule used by most private hospitals and practitioners ▪ Considerable institutional and soft powers 	<ul style="list-style-type: none"> ▪ Financial – protecting physicians’ ability to dispense drugs, minimizing role of MCOs, advocate fee increase ▪ Organizational – exert influence on policy process, maintain privileged position and relevance ▪ Consumer protection – addressing complaints against members made by the public 	<ul style="list-style-type: none"> ▪ Low support ▪ But MMA usually not overtly political ▪ Strong internal disagreement within MMA ▪ MMA position on policies is taken by leadership i.e. no formal voting process ▪ Skeptical about rationale; raised concerns over role of GPs under 1Care; unhappy with engagement process

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care (Continued)

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
MMA House Officers, Medical & Specialists (SCHOMOS)	MMA section for government / public sector physicians	<ul style="list-style-type: none"> ▪ Largest non-governmental representative group for public physicians ▪ Strong negotiating arm for govt doctors, with regular meetings with DG and other high-level MOH officials, on issues such as welfare, pay, and allowance and working conditions 	<ul style="list-style-type: none"> ▪ Financial – advocate for public doctors’ working conditions, fees; provide guidance to new physicians 	<ul style="list-style-type: none"> ▪ Non-mobilized as a unit separate from MMA ▪ But favor 1Care as see potential of increased remuneration
MMA Private Practitioners Section (PPS)	MMA section for private physicians	<ul style="list-style-type: none"> ▪ Negotiating arm of MMA for private doctors on issues such as disposal of clinical waste, FOMEMA, SOCSO, MCOs and the Private Healthcare Facilities and Services Act ▪ Linkages to other private practitioner associations, i.e. FPMPAM 	<ul style="list-style-type: none"> ▪ Financial – advocate for private doctors’ interests and reducing regulation requirements, influence of MCOs 	<ul style="list-style-type: none"> ▪ Non-mobilized (as a unit separate from MMA) ▪ But oppose 1Care due to payment changes, dispensing
Federation of Private Medical Practitioners' Associations, Malaysia (FPMPAM)	National body representing doctors in private practice in Malaysia	<ul style="list-style-type: none"> ▪ Largest and most widely represented private practitioners' group; national and 7 state associations; GPs and specialists; >5,000 members ▪ Considerable financial resources; many members of middle, upper-middle class, societal elites ▪ Access to key MOH decision-makers; meets on issues with MOH, MMC, MMA 	<ul style="list-style-type: none"> ▪ Financial – advocate for increasing private doctors’ fees, maintaining drug dispensing, reducing administrative requirements, reducing influence of MCOs, maintaining fee-for-service 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Main objection to 1Care due to proposed capitation system ▪ Specialists which benefit from lack of referral system for private sector want to maintain this ▪ Claims 1Care will increase their administrative fees
Malaysian Pharmaceutical Society (MPS)	National association for pharmacists	<ul style="list-style-type: none"> ▪ Largest association for pharmacists; public and private; committees in 11 states, ~2,600 members ▪ Access to key MOH decision-makers; meets on issues with MOH, MMC, MMA ▪ Publishes Malaysian Journal of Pharmacy 	<ul style="list-style-type: none"> ▪ Financial – advocates on behalf of pharmacists’ working conditions, favor dispensing separation as are in direct competition with GPs 	<ul style="list-style-type: none"> ▪ Low support ▪ Favor 1Care primarily due to dispensing separation but not highly mobilized
Association of Private Hospitals Malaysia (APHM)	National association of private hospitals and medical centres	<ul style="list-style-type: none"> ▪ Primary representative of private hospitals; >130 members ▪ Access and regular meetings with key govt decision-makers ▪ Participation in working groups i.e. Malaysia Productivity Corp (MPC), Ministry of Int’l Trade (MITI), Malaysia Trade & Development Corp ▪ Provides licensing and accreditation to private hospitals 	<ul style="list-style-type: none"> ▪ Financial – advocates on behalf of private hospitals, opposes reforms that would interfere with financial interests, promotion of health tourism activities; favors govt subsidies 	<ul style="list-style-type: none"> ▪ Non-mobilized ▪ Expressed support for SHI in general terms, could win out w/govt subsidizing private services, would need more info on payment mechanisms

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care (Continued)

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
Primary Care Doctors Organisation Malaysia (PCDOM)	Organization for GPs	<ul style="list-style-type: none"> ▪ Major association for private GPs in Malaysia ▪ Close linkage to MMA and key health policy decision-makers ▪ Engages in policy discussions regarding primary care practice and role of GPs ▪ Petitions MOH regarding policies they oppose i.e. Private Healthcare Facilities & Services Act 	<ul style="list-style-type: none"> ▪ Financial – advocates on behalf of benefits for GPs, to improve fee structure and benefits, while reducing administrative requirements ▪ Private GPs get much of revenue from dispensing drugs (consultation fees are capped) 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Against proposed capitation and family doctor system ▪ Against dispensing separation ▪ Increased maintenance and overhead costs to meet standards
Academy of Family Physicians Malaysia (AFPM)	Organization for GPs	<ul style="list-style-type: none"> ▪ Close linkage to MMA and key health policy decision-makers; ~500 members ▪ Engages in policy discussions regarding primary care practice and role of GPs ▪ Provides training in family medicine; promote standards of medical care ▪ Publishes journals, research, newsletters 	<ul style="list-style-type: none"> ▪ Financial – advocates on behalf of benefits for GPs, to improve fee structure and benefits, while reducing administrative requirements ▪ Private GPs get much of revenue from dispensing drugs (consultation fees are capped) 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Against proposed capitation and family doctor system ▪ Against dispensing separation ▪ Increased maintenance and overhead costs to meet standards
NGO/Civil society				
Malaysian Society for Quality in Health (MSQH)	NGO promoting safety and quality provision of medical services	<ul style="list-style-type: none"> ▪ Brainchild of key health stakeholders – MOH, MMA, APHM ▪ Develops and reviews health care standards; conducts accreditation; advises and consults MOH on quality improvement; member of committees and TWGs ▪ Institutional and normative power to shape policies, grant accreditation 	<ul style="list-style-type: none"> ▪ Consumer protection – promotes by developing and upholding quality standards in health care delivery 	<ul style="list-style-type: none"> ▪ Non-mobilized ▪ May take on additional roles due to autonomous functions but changes in role under 1Care not fully clarified
National Consciousness Movement (ALIRAN)	Malaysia's oldest human rights NGO (est. 1977)	<ul style="list-style-type: none"> ▪ Discursive and normative power to frame social issues and influence public perception and awareness ▪ Committee members are primarily middle-class academics and activists ▪ Monthly newsletter, website, social media; alternative to mainstream press ▪ Non-profit, independent, financing through donations ▪ Founded by Chandra Muzaffar, prominent political scientist 	<ul style="list-style-type: none"> ▪ Ideological – human rights, social justice, multi-ethnic society, health as a human right ▪ Consumer protection – promotes public and consumer good, environmental issues, partner with Bersih, CAHCP 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Endorses CAHCP position on health policy ▪ Concern over cost escalation, outsourcing contracts to corporate interests using private funds

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care (Continued)

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
Coalition for Clean and Fair Elections (BERSIH)	NGO promoting electoral reform	<ul style="list-style-type: none"> ▪ Endorsed by 62 NGOs, including powerful and high-level orgs – Malaysian Trade Union Congress, PR coalition, human rights commission, Malaysian Bar ▪ Rallies have drawn from 10,000 up to 300,000 people ▪ Discursive and normative power to frame social issues and influence public perception and awareness 	<ul style="list-style-type: none"> ▪ Ideological – deeply rooted beliefs of democracy and transparency ▪ Consumer protection – protecting citizens from corruption in electoral process and other sectors including health 	<ul style="list-style-type: none"> ▪ Medium opposition ▪ 1Care cited as an issue during Bersih 2.0 rally, due to perceived corruption in awarding govt contracts
Federation of Malaysian Consumer Associations (FOMCA)	National coalition of consumer associations	<ul style="list-style-type: none"> ▪ Most extensive relations with govt of all NGOs; serves on national advisory board for consumers, national economic council; has permanent representatives for each of the govt ministries ▪ Primary source of consumer advice regarding health, food, products, finance; publishes price comparisons ▪ No health-specific consumer body exists in Malaysia yet 	<ul style="list-style-type: none"> ▪ Consumer protection – promotes consumer interests and health safety ▪ Organizational – maintain relevance and key relationships with government 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Concern that rising administrative costs will be passed on to consumers; oppose lucrative contracts to private firms
Consumer Association of Penang (CAP)	State consumer association	<ul style="list-style-type: none"> ▪ Decades of experience as key player in health policy discussions ▪ Regularly makes submissions on federal budget ▪ Disseminates information via web, pamphlets, newspapers, press releases ▪ Often critical of government health policy, including rising care costs 	<ul style="list-style-type: none"> ▪ Consumer protection - advocacy, public education and policy input on all sectors including health ▪ Promote cost-effective, high-quality health care 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Concern over higher drug costs and rising administrative costs will be passed on to consumers; oppose lucrative contracts to private firms
Malaysian Trade Union Congress (MTUC)	Malaysia's oldest & largest national trade association	<ul style="list-style-type: none"> ▪ Unions affiliated to MTUC represent all sectors; ~500,000 members ▪ Serves as representative for workers in negotiations with govt on labor issues ▪ Track record of negotiation with government, i.e. as part of CHI and CAHCP engaged in massive efforts against healthcare privatization 	<ul style="list-style-type: none"> ▪ Financial – promote financial interests and working conditions of members; increase union membership and dues 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Reject changes that will cause members to pay higher income tax ▪ Concern over membership – granting benefits could reduce role of the union in protecting workers

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care (Continued)

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
Consumers (Low-income)	Citizens at bottom 40% income level (B40)	<ul style="list-style-type: none"> Represents approximately 10-12 million Malaysians Live in both urban and rural areas; more likely to be informally employed or unemployed; low coverage of private health insurance Strong voting base for BN coalition 	<ul style="list-style-type: none"> Financial – avoid additional health-related fees & taxes 	<ul style="list-style-type: none"> Non-mobilized But maintaining entitlement to free/subsidized services seen as critical component of BN platform
Consumers (Middle-Upper Income)	Citizens at middle 40% (M40) and top 20% (T20)	<ul style="list-style-type: none"> Represents approximately 16-18 million Malaysians More likely to live in urban areas, be formally employed, and have private and/or employer-sponsored insurance Strong voting base for PR opposition coalition 	<ul style="list-style-type: none"> Provider choice and quality – maintain existing choice and quality of healthcare providers Financial – avoid additional health-related fees & taxes 	<ul style="list-style-type: none"> Low opposition Reject the idea of mandatory tax contribution; unhappy with limitations on choice
Industry				
Small / Medium Enterprise Association of Malaysia (SME)	National representative body for SMEs	<ul style="list-style-type: none"> 13 branches; 3,000 indirect members, 500 direct members, comprising organizations and companies across variety of sectors Engages in policy discussions with government decision-makers SMEs identified as pillar of economic growth in BN's federal budget 	<ul style="list-style-type: none"> Financial – advocate for regulations to promote interests and growth of SMEs; avoid paying additional benefits to workers 	<ul style="list-style-type: none"> Non-mobilized
Life (LIAM), General (PIAM), Takaful (MTA)	Health Insurance Industry	<ul style="list-style-type: none"> Major insurers providing health products – life, general, takaful (Islamic mutual insurance) Private health insurance represents ~6.5% of THE and ~0.3% of GDP Close linkage to financial regulator - Bank Negara Malaysia 	<ul style="list-style-type: none"> Financial – promote growth in PHI market share; oppose regulations that would cut down on profits (i.e. limits on underwriting) 	<ul style="list-style-type: none"> Non-mobilized Role of private insurers under 1Care not fully clear but there would still be option to purchase complementary / top-up PHI Relative size of PHI to other insurance products small
Managed Care Organization s / TPAs	Managed Care Industry	<ul style="list-style-type: none"> ~30 MCOs registered in Malaysia Minimally regulated by govt; MCOs have power to set own fees and negotiate with providers, create provider networks 	<ul style="list-style-type: none"> Financial – reduce regulatory restrictions, promote growth in market share 	<ul style="list-style-type: none"> Non-mobilized No collective organization for MCOs so did not mobilize

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care (Continued)

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
Malaysian Organization of Pharmaceutical Industries (MOPI)	Represent pharmaceutical industry	<ul style="list-style-type: none"> ▪ Membership of all 42 major pharmaceutical manufacturers ▪ Pharmaceutical market estimated at RM4.29 billion (US\$ 1.22 billion) ▪ Holds regular dialogue with MOH, Ministry of Intl Trade & Industry, National Pharmaceutical Control Bureau to discuss policy resolve issues in industry ▪ Individual members govt-linked i.e. Pharmaniaga has 15-year contract to supply drugs to government hospitals; major shareholder is GLC 	<ul style="list-style-type: none"> ▪ Financial – advocate for regulations to promote industry interests and growth; obtain government concessions 	<ul style="list-style-type: none"> ▪ Non-mobilized ▪ 1Care policy did not provide specific details i.e. cost control mechanisms on drugs that could potentially mobilize this group; overall would want to maintain lucrative govt concessions
Academics				
Academics	Professors, members of academia	<ul style="list-style-type: none"> ▪ Conduct research, present evidence, write papers on government policies ▪ Shape and frame issues through discursive power, subject area expertise ▪ Some well-known, trusted by public (i.e. Jomo KS, prominent economist, speaks out against privatization; Chandra Muzaffar, political scientist, founder of ALIRAN) 	<ul style="list-style-type: none"> ▪ Ideological – promote strongly held beliefs regarding social, economic issues, including health policy and the role of govt 	<ul style="list-style-type: none"> ▪ Non-mobilized as a collective unit; but overall opposition as individuals ▪ Those in opposition to 1Care mobilized via groups such as CAHCP, ALIRAN
Stakeholder coalitions on health policy				
Citizens' Healthcare Coalition (CHC)	Coalition in opposition to 1Care (formed in 2012)	<ul style="list-style-type: none"> ▪ Primarily an alliance of political and financial interest groups ▪ 17 NGOs, doctors, citizens; members include FPMPAM, GP groups, PR coalition ▪ Coordinator / spokesperson is prominent MP for PKR party ▪ Funding and launch of high-visibility social media campaign, '<i>TakNak 1Care</i>'; hosting of public forums to discuss 1Care 	<ul style="list-style-type: none"> ▪ Political - opposition party capitalizing on any proposed scheme that would give them an edge in the upcoming election ▪ Financial – FPMPAM, other physician groups safeguarding interests, preventing change in provider payment mechanism, dispensing 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Rejects 1Care, calls for maintaining status quo ▪ Framed position as concern for public welfare

Table 8. Detailed Stakeholder matrix – power, interests, and position on 1Care (Continued)

Stakeholder	Who are they?	What are their resources and what power do they have?	What are their interests?	What is their position on 1Care?
Primary Care Providers' Coalition (PCPC)	Coalition of GPs (formed in 2010)	<ul style="list-style-type: none"> ▪ Coalition of medical associations, including MMA, AFPM, PCDOM ▪ Represents a large group of some of the most powerful physician associations in the country; has strong support from MMA ▪ Funded by members and donations; hosted GP Summit in 2010, chaired by MMA President ▪ Produce policy suggestions from private sector perspective to present to MOH 	<ul style="list-style-type: none"> ▪ Financial – advocate for GPs benefits i.e. maintain current fee-for-service provider payment mechanism and ability to dispense drugs, avoid additional regulation 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Specific concerns of GPs: loss of income due to capitation payments and inability to dispense medicine; increased administrative and overhead costs required to meet regulation standards; requirement to be family health doctors
Coalition Against Health Care Privatisation (CAHCP)	Coalition opposed to health privatization policies (formed in 2005)	<ul style="list-style-type: none"> ▪ Primarily an alliance of academic, ideological, public interest groups ▪ Collection of 81 civil society members, including academics, physicians, NGOs, labor unions (MTUC), socialist party, Aliran, consumer groups (FOMCA, CAP) ▪ Secretary is MP for PSM party (only seat held by PSM) ▪ Experience rallying support against policies (i.e. campaigned against full-paying patient wards) ▪ Access to high-level MOH decision-makers 	<ul style="list-style-type: none"> ▪ Ideological – belief that government should be primarily responsible for financing and provision of healthcare ▪ Consumer protection – seek to safeguard the public interest ▪ Political – close alliance with opposition and socialist party 	<ul style="list-style-type: none"> ▪ Strong opposition ▪ Rejects 1Care, calls for govt health budget increase, pull-back of privatization, freeze on new private hospital, removal of private contracts for drugs and support services, end to ‘cronyism’
Citizens' Health Initiative (CHI)	Coalition opposed to health privatization (formed in 1997)	<ul style="list-style-type: none"> ▪ (Now inactive – precursor to CAHCP) ▪ Initiated by members of MMA, CAP, academics from Universiti Sains Malaysia; endorsed by NGOs, labor unions (MTUC), individuals, DAP ▪ Successfully advocated against 1999 govt policy that would have increased corporatization of public hospitals 	<ul style="list-style-type: none"> ▪ Ideological – belief that government should be primarily responsible for financing and provision of healthcare ▪ Consumer protection – seek to safeguard the public interest 	<ul style="list-style-type: none"> ▪ N/A (inactive)

3.4.2 Stakeholder interests

Organized interests from powerful stakeholders – even when representing a minority – may have a disproportionate influence of the outcome of a policy (Fox and Reich 2013). Health reforms often place concentrated new costs on powerful, well-mobilized groups, and dispersed benefits on non-organized groups (Roberts et al. 2003b).

In this analysis, I define ‘interests’ broadly, as shared concerns of actors that have a stake or involvement in the health care system. This encompasses vested interests, in which individuals or groups seek to gain power and/or economic benefit, but also motivations that originate from a perceived moral obligation, such as the right to health. An example of the latter would be ideological interests of academics which opposed 1Care and supported increasing tax-based funding to health, claiming the government had a moral and social obligation to provide health care to its people.

The *Policymaker* tool includes several interest types as default options in the tool: financial, ideological, organizational, humanitarian, self-interest, political, and religious. Based on the stakeholders and context of this analysis, I adapted the list to identify six types of interests that played a major role in the outcome of 1Care: financial, political partisanship, bureaucratic, ideological, consumer protection, and provider choice and quality.

Financial interests

Stakeholders with financial interests seek to maintain or improve their remuneration and working conditions, or to promote growth in their share of the health care market. Financial interests are also relevant to the individuals and companies that would be mandated to pay wage-based SHI premiums.

Historically, medical associations and providers have resisted national health reforms which limited their economic independence and patients' freedom of choice (Fox and Reich 2013). Organizations representing private providers were almost unanimously against 1Care. Although they frequently cited issues like patient choice and decreased quality of care in their public statements, their true root of their opposition was due to financial interests.

Some of the strongest opposition to 1Care came from the Federation of Private Medical Practitioners' Association of Malaysia (FPMPAM), which called for an end to 1Care and 'limited reform' by way of improving the management of public healthcare, but otherwise maintaining the status quo (Bridel 2012). FPMPAM and private general practitioner (GP) groups, such as PCDOM and AFPM, argued that the national health insurance fund would function as a middle-man, adding layers of bureaucracy, and therefore increasing costs, while forcing additional tax burden on the public.

Private practitioners had 'vested interest in retaining the existing public-private mixed system, with doctors in the private sector paid on a fee-for-service basis' (Chee and Por 2015). GPs were especially adamant against moving away from fee-for-service towards capitation, as they perceived they would be losing out – caring for more patients and at a greater intensity, while earning less. Another highly contentious issue for GPs was 1Care's provision for separation of prescribing and dispensing – doctors in Malaysia have long been able to dispense medicines, and this accounts for a large part of GPs' income, as consultation fees have a government mandated ceiling.

According to statements made at a 2011 GP Summit, capitation was 'an untried and ill-tested mode of reimbursement, which most GPs fear and oppose. There is anxiety that their income would be constrained or even fall, and that unequal distribution of variously ill or well patients or citizens, would place unnecessary burden of proof or luck on the GP, besides the necessary

increase in paper work, documentation and possible red tape, audit, checks and balances. This will increase administrative costs of care and service, which are already unreimbursed and not identified as reimbursable, under such schemes' ("General Practice Conundrum: GPs at the Crossroads. Memorandum of the Coalition of Primary Care Providers Malaysia" 2011).

At the specialist level, one interviewee indicated that physicians did not get involved in policy debates 'unless it affects their own rice bowl,' which 1Care was perceived by many to do (MHSR Interview #3). Like the GPs, specialists were wary of additional oversight and administrative requirements that would be imposed under 1Care. As another interviewee observed, physicians were 'suspicious of the fact that this was going to be a much more transparent system. Now, suddenly the Ministry of Health is going to propose something that is going to hold the purse string. They are already going to look at pricing, quality and sharing of data' (MHSR Interview #11).

Some specialists opposed 1Care's imposition of a gatekeeping system because they benefited from the lack of a referral system in the private sector, allowing patients to bypass GPs and consult specialists directly on a fee-for-service basis. This was particularly relevant for non-hospital-based specialists, such as dermatologists.

Notably, the Malaysian Medical Association showed little enthusiasm towards 1Care, although ultimately it agreed to support the initiative and played an active role in the technical working groups. With its mix of public and private providers, GPs and specialists, the MMA members have different financial interests at stake. Although it is the largest body of providers in Malaysia, the MMA does not have a formal voting mechanism to determine its institutional positions; the senior level officers therefore tend to be the more influential voices in health reform debates, whose views do not necessarily reflect the majority of members. The MMA saw a change in leadership in 2011; whereas the outgoing president, Dr Quek described the

reform as ‘some good and some bad’ and questioned whether it was the most suitable option, the incumbent Dr Cardoso offered support of 1Care but admitted it was ‘a difficult process to arrive at a position’ (Chee and Por 2015).

Several important stakeholders with financial interests remained non-mobilized. The Association of Private Hospitals (APHM) did not take a strong public stance on the reform; some of its members expressed tentative support for a national health insurance concept, which could prove beneficial by subsidizing access to private hospitals for civil servants and other groups. According to one interviewee, the APHM did not feel especially threatened about competing against the public sector on a level playing field, ‘because as it stands, I think for the public sector to come to the level of a private hospital today, it won't be in my lifetime’ (MHSR Interview #36).

The insurance industry also did not visibly mobilize against 1Care, despite the potentially detrimental impact on its market share. Although SHI would be compulsory with no opt-out option, the 1Care concept paper specified that there would remain a role for private health insurance, to provide luxury services or as a complementary insurance to cover co-payments. This, combined with the relatively small market for private health insurance (most PHI was sold as a rider to life insurance policies), may have played a role in the industry's inertia. Whereas private insurers have ‘fought tooth and nail to protect their independence and their incomes’ (Preker et al. 2013) in countries like the U.S., in Malaysia ‘insurance companies are not a big actor with regards to political power’ (MHSR Interview #8).

Imposing SHI premiums would represent an additional financial burden to households in the immediate and short term, but, if well-implemented, would result in easing the escalation of health care costs in the longer term (Chee and Por 2015). Nonetheless, the mandatory contribution was one of the more controversial elements of the 1Care plan, with opponents of

the reform spreading the claim that 10 percent of monthly income would go to SHI. The government's commitment to subsidize SHI contributions for poor families would fall considerably short, based on the estimates presented in the 1Care concept paper.

Political partisanship interests: PM Najib and Barisan Nasional

For this analysis, I consider political interests as those relating to the advancement of political parties' control of the government through the process of winning votes and Parliamentary seats.

In the case of the ruling Barisan Nasional coalition, the political interest was to maintain hold of the government, regain the two-thirds supermajority lost in the 2008 elections, and increase the percentage of popular vote. PM Najib's political interest was to maintain the strong support of his party and his position as the head government.

What was the potential impact of 1Care on the Prime Minister and BN's political interests? For politicians in the executive, the successful introduction of programs such as national health insurance demonstrates their administration has made an important achievement (Immergut 1992). The justification for adopting social health insurance was made in the 1Care concept paper and reiterated by PM Najib in his public announcement of the reform. Numerous policymakers and government officers interviewed by the MHSR team cited the necessity for a sustainable system of health financing, and the limited fiscal space available for health budget increases as per Ministry of Finance policy (Croke, Virk, and Almodovar-Diaz 2015).

On the other hand, proposing wholesale transformation of the health system would incur considerable risk to a government in an already precarious position. In addition to BN's poor performance in the 'political tsunami' election, PM Najib had recently ascended to the highest office amidst the growing turmoil of an economic crisis and the ignominious resignation of his

predecessor, PM Badawi. In short, PM Najib had his work cut out for him. Repairing the economy was of paramount importance, both to the country and to his party's survival; health reform was far from the public agenda.

The political calculus with regards to 1Care was further complicated by the fact that Najib's UMNO party predominantly catered to the rural Malay / Bumiputra population that relied most on the subsidized public system. As one political analyst observed, 'any radical change to the role of the state as provider of public health care poses problems of political legitimacy for a ruling coalition which has historically projected itself as delivering socioeconomic benefits to the population and especially to its principal constituency, the rural Malays' (Barraclough 2000). A government officer took this sentiment even further, suggesting that implementing such a reform in the current environment with a weakened government would be 'political suicide' (MHSR Interview #38).

The timing of the reform was also an important factor relative to BN's political interests. Governments typically introduce major reforms after winning an election; 1Care was first presented to the Cabinet and Economic Council in mid-2009, about eighteen months after the 2008 election. But given the political and economic circumstances, health reform was not a priority for PM Najib. Rather than seizing on the post-election timing, the PM asked for more analysis to be conducted, and stakeholder engagements to be made, before moving forward to produce a detailed implementation plan and blueprint for 1Care. Thus, the policy process was drawn out over the course of the next two years, with technical staff meeting with stakeholders and technical working groups. As discussed further in the section on bureaucratic interests below, the administrative units within the Ministry of Health were skeptical of 1Care and had little desire or incentive to move the process along.

1Care lacked a high-level political champion that could ensure its placement on the policy agenda. The policy was drafted by the technical National Health Financing unit of the MOH, which had limited ability to influence the highest levels of political leadership. The Minister of Health, Liow Tiong Lai, was deeply embroiled in a leadership crisis within the MCA between 2009 and 2010, heading one of three factions vying for power over the party. One of the policy's stronger proponents, Director-General Ismail Merican, retired from office in 2011. BN's shelving of the policy prior to the 2013 election, with no mention of the reform in its manifesto, suggests that supporting 1Care was not deemed politically expedient at the time.

Political partisanship interests: Pakatan Rakyat

The opposition coalition had clear political interests at stake, as it sought to capitalize on successes from the 2008 elections, maintain its hold on five states, and to gain enough Parliamentary seats to oust BN from its seat of power in the next general election.

As with many opposition parties, the Pakatan Rakyat (PR) coalition adopted a strategy of denouncing proposals adopted by BN regardless of actual policy views. PR leaders were quick to demonize 1Care as yet another opportunity for the long-reigning BN coalition to benefit private crony companies through lucrative contracts. A number of senior MPs from PR joined forces with FPMPAM to form the Citizens' Healthcare Coalition, which mounted the *TakNak 1Care* campaign.

Regarding opposition tactics, one MOH officer noted: 'In the last general elections GE13, the opposition party really felt that they had the chance of changing government. They were banding together whatever they could, anything that could actually be against the government. Of course they said what [1Care] was proposing is privatization of the health care system. We said no, it's not, but in that point in time it was about winning the elections. Then they worked

with the provider group whose whole agenda was stopping 1Care and transformation. It was a good match for them at that time' (MHSR Interview #11).

As a result, the 2013 general election manifesto for PR vowed to 'Reject all attempts to introduce a healthcare tax such as 1Care; Ensure free healthcare for all Malaysians through government hospitals while incentivizing the private sector to provide healthcare services at a reasonable rate; Offer free ward service to all citizens in all government hospitals by abolishing fees for Class 2 and Class 3 wards' (Pakatan Rakyat 2013). The opposition presented a 'wish list' that was unlikely to be feasible, administratively and financially; a skeptical interviewee noted that 'They want to topple the government because they want to take over the government, but I am not sure when they take over the government, can they give the money [for health care] that we want' (MHSR Interview #27).

Bureaucratic interests

For bureaucrats, major health reforms, and particularly national health insurance, provide ample domain to exercise administrative control (Immergut 1992). Weber's bureaucratic theory identifies six characteristics of bureaucracy, beginning with the hierarchical management structure, in which authority and responsibility is clearly delineated for each position, and each level controls the levels below and is controlled by the level above. Bureaucratic interests, therefore, are held by actors that exercise control in a bureaucratic system and are resistant to changes that would limit this power.

In the Malaysian MOH, bureaucratic interests are clearly delineated along administrative and technical lines. The administrative units of the MOH, headed by the Secretary General, oversee finance, human resources, procurement; while the technical units are the responsibility of the Director General, and comprise the public health program, medical program, research and technical support program. Tensions between these two wings of the MOH were evident in

many of the interviews conducted by MHSR researchers. Several interviewees suggested that whereas the technical staff tended to be supportive of comprehensive health system reform, the administrative officers were often skeptical.

As one technical officer theorized:

‘If you’ve seen the 1Care document, it’s written from a very technical perspective. It doesn’t talk much about the administrative changes. Although it says that things need to change. The admin people who are pure civil servants, they couldn’t see what’s their future in this change. They feel threatened [...] the people from the finance division, people who take care of human resource. We said the Ministry of Health of the future should be small, lean and technically strong. We were silent on the administrative part of these changes because we didn’t work out all those details yet. It was very hard to see how they would fit in. Administratively, what would happen? They were nervous about it. In fact, one person said in a meeting from the admin that they don’t see what their role is in the future’ (MHSR Interview #11).

Due to the intensely hierarchical nature of Malaysia’s MOH, bureaucrats have considerable power to stymie health reforms. Unless clear instructions are given from the highest political levels above the MOH, the administrative sections have power to create barriers and cause delays that could result in extending the timing for implementation of reform.

Ideological interests

Stakeholders with ideological interests held deeply rooted beliefs with respect to the government’s role in the provision and financing of health care, and the population’s entitlement to health.

According to its website, the Ministry of Health’s mission is to ‘facilitate and support the people to attain fully their potential in health; to ensure a high-quality health system that is customer-centered, equitable, and affordable; with an emphasis on professionalism, caring and teamwork value, respect for human dignity, and community participation’.¹⁰ This mission

¹⁰ From MOH website: <http://www.moh.gov.my/english.php/pages/view/131>

drives the ideology of the MOH, which at times clashes with the ideology of the MOF and economic advisory units such as EPU. The MOH, for example, has not necessarily been supportive of privatization reforms promoted heavily by the EPU and adopted by PM Mahathir in the 1980s and 90s.

The MOH justification for the 1Care policy was rooted in the belief that the Malaysian population had a right to affordable, high-quality care, that ensured patient satisfaction. Given the constraints imposed on the health budget by the Ministry of Finance, the MOH had to explore options that result in sustainable universal coverage. This was the position of the National Health Financing Unit, which drafted the policy, and promoted principles such as equity, fairness, and solidarity.

On the other hand, several external stakeholders strongly opposed the 1Care reform on ideological grounds. Critics asserted that the government should maintain responsibility for its population via a tax-funded, public system, pointing to Malaysia's comparatively low level of spending on health as a percentage of GDP. The Citizens' Health Initiative, which would later form the basis for the Committee Against Health Care Privatization, declared in its manifesto: 'We believe that efficient, rational, and socially just healthcare can be better delivered by a publicly-funded healthcare system which is regulated according to accountable and transparent criteria' (*Aliran* 2006).

As I discuss in Section 0, stakeholders with ideological interests, such as academics and civil society, were also skeptical of the government's role in establishing an autonomous National Health Financing Authority. Opponents pointed to previous experience with hospital corporatization and contracting-out of services, which had driven cost inflation for drugs and support services, and also highlighted the government's dubious practice of awarding lucrative contracts to government and politically-linked entities.

Consumer protection interests

Stakeholders with consumer protection interests provided a service to consumers and the general public, by spreading information and advocacy on health issues. The government and MOH are primarily responsible for regulating the quality of health care services, but several external stakeholders play a role in promoting transparency and informing consumers as a public good.

The primary civil society organizations involved in health policy are the Consumer Association of Penang (CAP) and the Federation of Malaysian Consumer Associations (FOMCA), both members of the Coalition Against Health Care Privatization (CAHP) which opposed 1Care. These organizations are motivated by ensuring the rights of consumers to basic needs, including healthcare, and to fight for fair prices and high-quality services for the public.

The CAP, in particular, has a history of criticism towards government health policy, arguing for an equitable and public-dominated health care system in its newspaper, pamphlets, and press releases, and publishing critiques on the rising costs of healthcare as long ago as 1983 (Barraclough 2000). Amongst all NGOs in Malaysia, FOMCA has the most extensive relations with the government, serving on the national advisory board for consumers, as well as the National Economic Council.

Provider choice and quality interests

Finally, stakeholders with provider choice and quality interests relates to individuals who seek to maintain their ability to choose health care providers at a reasonable level of quality.

Malaysians view access to a subsisted public system as a fundamental right which should remain the responsibility of the government, and will resist strongly any attempt to change this, even if in theory a new reformed system would offer similar access. The ability to choose

provider and quality is also considered sacrosanct to those who can afford it. Opinion polls suggest that middle-class consumers who are more likely to use private health services are also more likely to already be opposition supporters, which adds an important political dynamic to this interest group (Pepinsky 2015).

The expectation of free or virtually free care is entrenched as a fundamental aspect of public opinion and would therefore be difficult to reverse. With Barisan Nasional's reliance on rural populations (particularly in Sabah and Sarawak) and the votes of rural UMNO voters (in part because of gerrymandered parliamentary constituencies), there is a perception that the beneficiaries of the public health system would be most likely to favor the status quo and resist changes imposed by SHI.

As one high-level former official stated about the rural population:

'They will be very, very upset. In this country, anything other than free service will be upsetting. Because they so used to not paying for healthcare. So, somewhere along the line, you need a bold government. Of course, in that for that to happen, the government must be strong. So I don't think it's going to happen any time now. ... If the government is weak, when you do this, it will be political suicide. But, if they want to do healthcare financing, so it may be political suicide...they do not know how to tell the *rakyat*: Please pay for healthcare' (MHSR Interview #38).

3.4.3 Analysis of stakeholder coalitions against 1Care

Two major stakeholder coalitions mobilized against 1Care: the Citizen's Healthcare Coalition (CHC); the Coalition Against Health Care Privatisation (CAHCP). Although these coalitions shared a mutual objective of blocking 1Care, they otherwise varied considerably in their mission, membership, and methods. A third coalition, the Primary Care Providers' Coalition (PCPC), expressed serious concerns about the impact of 1Care on their livelihoods, and requested inclusion in the policy development process to ensure their interests were protected.

Citizen's Healthcare Coalition (CHC)

Unlike the pre-existing coalitions, CHC was formed specifically in response to the 1Care proposal. Its most visible members were FPMPAM and the PR opposition coalition; the spokesperson was a MP from the PKR party. The coalition was a marriage of convenience between financial and political interests. Despite these clear interests, the CHC successfully, if disingenuously, portrayed itself as a guardian of the interests of the *rakyat*.

The coalition spearheaded the *TakNak 1Care* campaign, which described itself as 'a group of ordinary citizens concerned about the government's desire to implement 1Care at the ignorance of the general population'.¹¹ The campaign relied heavily on misinformation and scare tactics, spreading messages across social media platforms, in addition to hosting public forums against 1Care (*see Annex 3 examples*). Through these methods, CHC drew on discursive power to frame 1Care as 'healthcare for sale' and 'privatization in disguise'.

FPMPAM and the opposition coalition used their access to mass media and social networks to spread the complement the message of *TakNak 1Care*. Both stakeholders had direct access to an important demographic – urban, middle and upper-class Malaysians; for PR, this population made up much of its constituency, and for FPMPAM, this population made up much of its clientele, as well as its member providers. Thus, both the interests and target audience for CHC were well-aligned.

Coalition Against Health Care Privatisation (CAHCP)

The CAHCP was formed in 2005 in response to the government's announcement of a range of privatization measures, such as the privatization of pharmacies and introduction of private wings in public hospitals (Barraclough 2000). The coalition of 81 NGOs, trade unions, and

¹¹ From <http://taknak1care.weebly.com/>

political parties comprised many of the signatories to the Citizen's Health Initiative (CHI), which had successfully campaigned against a 1999 government proposal to increase the corporatization of public hospitals and medical centers.

Notable CAHCP stakeholders included the National Consciousness Movement (ALIRAN), the Malaysian Trade Union Congress (MTUC), the Socialist Party of Malaysia (PSM), consumer groups FOMCA and CAP, and prominent academics and physicians. Although these stakeholders held somewhat varying interests as individuals, the group was largely a meeting of ideological, public, and political interests, predicated on a basic value of government responsibility to provide universal and equitable access to comprehensive care regardless of income level.

In 2006 the CAHCP issued a 'People's Proposal' for health, calling on the government to 'meet its responsibility to provide equitable and adequate health services to the *rakyat*'. The proposal demanded an increase in government health budget to 5 percent of GDP, inclusion of civil society in the reform process to ensure accountability, that the proposed national health authority be created by an act of parliament, and that any basic health package provided by NHI minimally include all treatments available at government facilities (*Aliran* 2006).

The CAHCP did not reject the idea of NHI outright, and agreed with several key principles, such as the removal of fee-for-service provider payment. Rather than denouncing a national health fund as inherently bad, the group was concerned about cost inflation and the possibility of government misuse of expanded health care resources to promote private interests. These concerns were not unfounded – both government medical stores and hospital support services saw a greater than three-fold cost increase after only one year of privatization (Chan 2010).

Furthermore, many contracts had been awarded to politically well-connected firms. The majority shareholder of Pharmanagia, awarded a 15-year contract to supply drugs to

government hospitals, is the GLC Boustead. The three companies awarded 15-year concessions to provide hospital support services were either owned by GLCs or had close connections to UMNO and the Mahathir family. The majority shareholder of Asia's largest private health group, IHH Healthcare, is the GLIC Khazanah Nasional.

When the 1Care concept paper omitted details on the administrative structure of the proposed National Health Financing Authority, CAHCP voiced concern about the government's conflict of interest between pursuing the public good and promoting the interests of the private healthcare provider industry. In response to the proposal, CAHCP demanded the government roll back privatization measures, including the contracting-out of medical stores and support services.

CAHPC deployed somewhat more nuanced tactics than the CHC's mudslinging campaign. It disseminated information through its website, press releases, and distribution of pamphlets; held meetings and demonstrations; petitioned the Prime Minister, and encouraged citizens to lobby their members of parliament (Chee and Barraclough 2007). With high-power members such as the largest trade union and consumer associations, the coalition had access to key government decision-makers in different ministries and economic, labour, and consumer advisory boards.

Primary Care Providers' Coalition (PCPC)

The PCPC was formed by medical associations including the Malaysian Medical Association (MMA), Academy of Family Physicians Malaysia (AFPM), Primary Care Doctors Organisation Malaysia (PCDOM), and GP provider networks such as Qualitas Medical Group (QSB) and Koperasi Doctor Malaysia (KDM). The coalition came together in 2010, hosting a GP Summit to collectively agree on policies, viewpoints, and reservations from private sector perspective to present to the MOH.

Combined, this coalition represented a large group of the major GP associations in the country, and received the support of the MMA, whose president chaired the summit. The grouping was a strong manifestation of shared financial interests; its mission was to lobby power to ‘help protect our profession and our position from unreasonable challenges and top-down regulatory oversight which are unfair, or which are too micromanaging or potentially discriminating’ (“General Practice Conundrum: GPs at the Crossroads. Memorandum of the Coalition of Primary Care Providers Malaysia” 2011).

The GPs had many grievances, starting with the 2006 Private Healthcare Facilities & Services Act, which they perceived to target GPs unfairly, while requiring unnecessary and micromanaging regulations that drove up administrative costs. In addition, they felt the fee schedule was too low, while unregulated MCOs placed even more restrictions on GPs to force them to accept lower fees.

The CPCP opposed 1Care, primarily due to its proposal of capitation-based payment and separation of providing and dispensing. In addition, the group cited ‘grave misgivings’ about public-private integration, citing ‘severe lack of understanding, trust and respect between the private sector and the public sector’ (2011, p4). As stated in the memorandum for the GP Summit: ‘there remain many serious doubts as to the GP’s continuing role and tasks. The planned registration of designated number of patients, the capitation reimbursement mechanisms, the gatekeeping function, pay-for-performance incentives, and the uncertain role of credentialing/accreditation, mandated continuing professional development, all pose serious problems and qualms for the future of GP practice’ (2011, p4).

However, the coalition also recognized the need for improvements to the health care system to ‘ensure equitable distribution of healthcare services to every resident and citizen’. Rather than attempting to set up roadblocks to 1Care, the GPs asked for engagement with the MOH in the

planning of the health reform, and a platform to discuss shared roles and responsibilities of the GPs as well as methods of reimbursement.

3.4.4 Stakeholder mapping: power and position

The mapping presented in Figure 15 below displays stakeholder power and position on the reform and demonstrates the major barriers to 1Care at a glance. Using the *PolicyMaker* framework, power is displayed on a three-level gradient: low, medium, and high. Power is determined based on the stakeholders' availability of financial, organizational, and symbolic resources to influence the policy, as well as the availability of direct and easy access to the decision-maker on the policy, and to mass media.

A number of stakeholders were considered 'high-power' in this analysis, based on their access to the tangible and intangible resources described above. However, the three-tiered power structure is limited in its ability to make a nuanced differentiation between the levels of power.

In Malaysia, as this thesis has described previously, the Prime Minister and senior UMNO leadership hold considerable power. With the executive powers overlapping with the judiciary and legislative branches, and with UMNO the dominant force within BN and the Cabinet, the locus of veto power resides with the PM and his party leadership (MacIntyre 2001). In 2009, when the 1Care concept paper was first presented, BN had lost its super-majority, but still maintained a comfortable 63 percent majority, or 140 of 222 parliamentary seats, that would allow it to push Bills through. As one interviewee put it succinctly: 'If the Prime Minister says, "Do it!" then it will be done' (MHRSR Interview #27).

Figure 15. Stakeholder mapping by power and position



Source: Policymaker tool. Key to power gradient: white box = low power; grey box = medium power; black box = high power

BN's component parties controlled several of the largest newspaper and media outlets in the country, targeting the major three ethnic groups, in addition to the Star, the largest paid English newspaper in terms of circulation. However, this did not translate to PM Najib using his power indiscriminately to promote any policy that held promise. As discussed in Section 3.4.2, the political interests of the PM and his party were at risk with the implementation of SHI and the perceived retraction of entitlement to a highly subsidized public system.

Although Najib supported 1Care in its conceptual phase, he had much larger political battles to face, starting with the ongoing economic crisis; the ineffective handling of which had precipitated his predecessor's resignation from office. It is also likely that the PM was reserving his political capital for what would be one of his largest challenges and a major economic initiative: implementing the Goods and Services Tax (GST). The GST bill was first read in Parliament in December 2009, but was delayed due to a massive public outcry against the bill, in addition to mounting objections from segments of UMNO (*Malaysian Insider* 2010). It was not until 2014, after the next election that GST was finally passed and began implementation the following year.

As a result, despite holding veto power, the PM opted not to exercise this power towards 1Care and did not actively engage the considerably large component of non-mobilized stakeholders that could have benefited from the reform. Health care reform was not a high priority for Malaysians or the government; BN's economic agenda took precedence at the time.

The policy's primary source of support was the NHF technical unit that devised the concept paper; the members of this unit devoted considerable resources, from mobilizing technical working groups, to hosting public forums on 1Care, to publishing news articles and rebuttals to negative press. Yet despite its proximity to key policy decision-makers, the NHF unit held

relatively lower power and was unable to garner strong support for the reform within the government, let alone externally.

Opponents of the 1Care reform utilized their power and resources fairly effectively, particularly in the case of the *TakNak 1Care!* campaign, as described earlier. The Citizens' Healthcare Coalition primarily relied on social media to disperse the campaign message, while the opposition political parties had a public platform and considerable access to the media. Despite this, the campaign did not elicit a high level of public outcry; there were no mass rallies against 1Care, as there have been against other policy proposals such as GST. Healthcare in general was not a high priority for the public, and neither proponents or opponents of 1Care successfully placed reform on the agenda. Rather than propose an alternative reform, the PR coalition opted to promote the status quo.

Several important stakeholders with financial interests remained non-mobilized. The Association of Private Hospitals (APHM) did not take a strong public stance on the reform; some of its members expressed tentative support for a national health insurance concept, which could prove beneficial by subsidizing access to private hospitals for civil servants and other groups.

The insurance industry also did not visibly mobilize against 1Care, despite the potentially detrimental impact on its market share. Although SHI would be compulsory with no opt-out option, the 1Care concept paper specified that there would remain a role for private health insurance, to provide luxury services or as a complementary insurance to cover co-payments. This, combined with the relatively small market for private health insurance (most PHI was sold as a rider to life insurance policies), may have played a role in the industry's inertia. There is also the possibility that certain stakeholders lobbied privately to the highest levels of

government, which could not be captured in this analysis (see Section 3.6.2. which discusses this limitation).

3.5 Applying Kingdon's multiple streams approach: what factors led to the failure of 1Care?

The success or failure of any reform is contingent on numerous contextual factors. As presented in this analysis, 1Care faced opposition from stakeholders with vested financial, political, and ideological interests. While the PM and government were initially supportive of 1Care – as evidenced by the Economic Council approval, and the PM publicly announcing the reform – this support did not translate into the ruling coalition exercising its power to back the health transformation reform as a national priority.

BN has demonstrated its willingness to support reforms that were high on its political agenda, even in the face of resistance from stakeholders. One of the most notable recent examples is the government's implementation of GST, despite multiple delays due strenuous resistance from the opposition coalition and the public, with protests against the tax drawing crowds of up to 50,000 people (*Malaysiakini* 2014).

Kingdon's multiple streams approach is a useful framework to understand the factors leading to 1Care's failure, and how and where stakeholder opposition thwarted the policy process. This is achieved by analyzing the individual components of the policy setting process – the problem stream, policy stream, and political stream – and addressing how stakeholders engaged with each stream. The analysis determines the extent to which, if any, a window of opportunity emerged, so that 1Care could be positioned on the national agenda.

Considering each stream separately provides an important lens on the stakeholder analysis. Although each stakeholder could theoretically be involved in all three streams, it is more likely

that stakeholders will specialize in one or two streams, in line with the type of power they wield (Larkin Jr 2012). Whereas politically appointed officials may have direct access to veto players and decision-makers (or play these roles themselves), the expertise and discursive power of academics and policy analysts means their strengths may lie in generating policies or framing issues.

The Problem Stream

To build the case for 1Care, the concept paper highlighted several problems ailing the health system – focusing on high out-of-pocket payments, a mismatch between public and private sectors, and sustainability issues in the face of rapidly expanding healthcare costs (Ministry of Health, Malaysia 2009). Yet these problems were technically complex – the intricacies of health financing and delivery are not easily explained to the lay public – and, most importantly, reflected anticipated problems for an unspecified future.

The Malaysian public had long been entitled to universal coverage of relatively good quality, highly subsidized services. Although there were issues with long queues and lower perceived quality in the public sector, the population was not clamoring for a complete overhaul of the health system. Even for those concerned about health care, these sentiments were eclipsed by much bigger problems – including rising oil and consumer item prices, ethnic inequalities, and government corruption (Nawab 2014).

Furthermore, Malaysia's health system was widely lauded as well-performing, both by global experts and by the MOH itself. A report by WHO consultants praised the country's achievement of 'remarkably high and equitable health status at a relatively low cost' (Shepard, Savedoff, and Hong 2002). Findings from a World Bank study concluded that Malaysia's health system was both inequality-reducing and pro-poor, as evidenced by the poorest quintile receiving significantly greater than 20 percent of the total subsidy (O'Donnell et al. 2007).

In Kingdon's framework, a problem is defined as a 'matter of concern that a critical mass of people want to change or affect' (Larkin Jr 2012, p28). Problem framing is a critical precursor to other efforts to drive policy change, and requires close attention by policy entrepreneurs (Mintrom and Luetjens 2017). To successfully frame policy, the problem definition must not only be more attractive than alternative ones, but also more compelling than competing issues (Roberts et al. 2003b). The case for health reform was not adequately presented in a way to suggest a crisis was at hand, nor did it take precedence over other problems; thus, the necessary groundwork was not laid to present a solution in the form of 1Care.

Stakeholders with financial interests, such as FPMPAM and other private physician associations, played an important role in framing the problem as a non-issue; one of the favored refrains of the *TakNak 1Care* campaign was 'if it ain't broke, don't fix it'. Political interest groups were also successful in capitalizing on public sentiment against reforming the health system; the opposition coalition repeatedly affirmed its commitment to upholding entitlement to a highly subsidized, tax-funded system.

As a result, there was no rallying cry for reform – the critical mass of people calling for change never materialized. In the face of an unclear problem, a concentrated and vocal opposition, and a skeptical public, policymakers were fighting an uphill battle from the very outset.

The Policy Stream

Rather than an organized, linear process, Kingdon famously described policymaking as 'organized anarchy', with different players, ideas, problems, and solutions coming together at various points throughout the policy cycle (Kingdon 1995). Despite this chaos, there is a clear need for a chronological hierarchy whereby an issue is first identified in the problem stream, to which the policy stream presents a concrete, feasible solution in response.

Here, too, 1Care policymakers failed to achieve the desired outcome. As described in Section 3.3.1, omissions in the concept paper, such as the contents of the benefits package and the amount of the premium and co-payments were seized upon by 1Care's opponents, and readily manipulated into alarmist soundbites, such as the headlines declaring a mandatory 10 percent income tax and an annual cap of six doctor's visits under the new system.

The NHF kept certain details deliberately vague; understandably, the more detail that was released, the greater potential for opponents to mobilize against the reform due to perceived losses. Yet even when tasked with engaging stakeholders, the Ministry remained secretive. When the technical working groups were formed to bring in stakeholders on 1Care, the financing group was kept internal to the MOH. According to interviews with MOH officers, many stakeholders wanted to participate in the financing group, but the MOH was worried about releasing too much information.

As one interviewee stated, 'Let me go back to why 1Care, you know didn't work out so well. I think traditionally how we engage as a government, in the Ministry of Health, I would say, we don't engage people well. You call for a briefing and you call that engagement, for me that's totally nonsense. Because to them engaging the private sector means I call for briefing, I brief you and that's it' (MHSR Interview #16).

As with the problem, the solution proposed by policymakers was technically complex; key elements of the rationale for social health insurance – concepts such as risk-pooling and cross-subsidization – were not easily understood or accepted by the public. Even for stakeholders with a keen understanding of health financing and social health insurance, the proposed solution was not considered acceptable to many. One of the most salient arguments presented by 1Care opponents was that Malaysia spent considerably less on healthcare, as a percentage of GDP, in comparison to upper middle-income economies. In 2009, government expenditure

on health was equivalent to 2.71 percent of GDP; this allocation comprised 6.6 percent of the national budget and was significantly lower than oft-cited global targets such as the 15 percent Abuja Declaration. Academics from highly respected institutions, such as Universiti Sains Malaysia, were calling for alternative solutions such as ‘more progressive taxation regimes to improve universal access to quality care on the basis of need’, thereby dispensing with administrative and transactional costs of managing a national health insurance scheme (Chee-Khoo 2015).

In light of these arguments, the policy ‘solution’ proposed by the government was rejected by the public as an ‘abdication of responsibility’ (Chow 2011). Even if the public were willing to accept the government’s problem statement that health care costs were soaring, the fact that Malaysia was still spending relatively less on health care presented a compelling point against the policy. Coupled with the notion that 1Care would promote the ‘privatization’ of health care – long a bone of contention for Malaysians – proved fatal to the policy’s acceptance.

The policy stream was arguably the weakest link of the agenda-setting process and was susceptible to attacks from all interest groups. Social health insurance was, and remains, a frequently debated topic in global health. Ideological groups may have been willing to accept there were problems in the current health system but were predominantly opposed to SHI on the grounds that it was the government’s responsibility to maintain the highly subsidized entitlement to care. Ideological groups also objected to the idea of a National Health Financing Authority on the grounds that it would become yet another GLC – a lucrative vehicle for government investment. Relatedly, these groups stated that, before reforming the system, the government should address ‘leakages’ and rising costs due to contracting-out hospital services to private firms.

For stakeholders with political interests, a policy like 1Care was a welcome gift, providing ample fodder to accuse the ruling coalition for corruption and cronyism. The 1Care concept paper was also a boon to private physicians' groups – although their financial interests were at stake, these groups were able to frame their opposition to the reform as a social good, protecting the welfare of their consumers. FPMPAM and others adroitly pressed this advantage, presenting the evils of 1Care to the public, while conveniently neglecting to mention the policy's impact on their own financial interests.

Together, these interest groups successfully derailed the policy stream, blocking efforts of the Ministry of Health to provide clarification on elements of the reform. The weakened policy stream, combined with the lack of a well-framed problem, making the likelihood of passing the reform even smaller.

The Political Stream

The political stream is formed by changes in an administration, typically brought on by elections – the transfer of the majority power in representative bodies, the retirement or defeat of powerful legislators, or the election of new, charismatic public officials can all usher in opportunities for change (Larkin Jr 2012). The timing of policy reform, in relation to the political stream, is paramount. As the analysis in the previous section suggests, the 1Care reform was mistimed; not only were the PM and ruling coalition occupied by more pressing economic issues, but by dragging the policy and stakeholder engagement process over the course of several years after initial approval had been received, any potential window of opportunity was lost.

The primary actors blocking this stream were, unsurprisingly, groups with political interests at stake – most notably, the opposition coalition. The political climate preceding and throughout the development of the 1Care policy was a key factor of its demise. The 2008 election had set

the stage for a major mood shift of Malaysia's electorate; Barisan Nasional's loss of parliamentary majority in the national legislature, as well as 5 of 13 state elections, was an unprecedented defeat. Meanwhile, Pakatan Rakyat's surprising performance had changed the electoral landscape to a multi-party system. BN's declining approval rating, and accusations of systemic corruption and cronyism permeating all levels of Malaysia's government, provided ample opportunity upon which PR readily capitalized.

Governments approaching the end of their term are generally unwilling to take on unnecessary political risks; for BN, the margin of error for the 2013 elections was becoming razor-thin, and the prospect of victory for PR was not out of the realm of possibility (Nehru and Tran 2013). Whereas the opposition coalition made specific campaign promises against 1Care in its 2013 election manifesto, BN made no reference to the policy. Rather than gamble on a risky health reform, BN bolstered its appeal to the electorate by relying on its long-standing platform on economic growth. PM Najib launched a series of well-received reforms – the Economic Transformation Programme (ETP) in 2010, with an aim to make Malaysia a high-income country by 2020; and the 1Malaysia People's Aid (BR1M) in 2012, doling out cash to low-income families (Nawab 2014).

Despite these efforts, BN's poor performance in the 2013 elections, winning only 46.5 percent of the popular vote, left the ruling coalition in an even more precarious position, which would not bode well for future attempts at health care reform.

The Window of Opportunity

Windows of opportunity may arise due to exogenous or endogenous factors; a strategic policy entrepreneur recognizes when a window naturally arises, or proactively seizes the chance to create one by merging the streams. Without the coupling of the problem and political streams, no policy can emerge; solutions may exist and receive support from stakeholders, but they are

unlikely to be capitalized upon if the national mood is not receptive (Ridde 2009). Even under more favorable circumstances, policy windows are of limited duration, and subject to unanticipated results (Kingdon 1995).

1Care lacked a strategic and high-level policy entrepreneur that could ensure its placement on the policy agenda. The technical staff in the National Health Financing unit were not senior enough to serve this role; the likely candidate would typically be the Minister of Health. At the time of 1Care’s introduction, Minister Liow Tiong Lai was in the midst of a leadership crisis within his MCA party, where he served as Vice President. The Prime Minister described 1Care as ‘interesting and intriguing’, but neither he nor his Economic Council members were willing to devote significant political capital towards the reform’s adoption (MHSR Interview #12).

Absent any natural disasters, the best chance for a window of opportunity would have been after the 2008 elections. Despite BN’s poor performance, the majority rule was maintained, and the PM showed initial support for 1Care in 2009 that could potentially have been capitalized upon. However, the lack of a well-placed political champion for 1Care made the policy subject to the whims of bureaucratic actors with limited motivation to push the reform.

Figure 16. Application of Kingdon’s multiple streams approach to 1Care

	Issues with Stream	Key types of Interests Blocking Stream
Problem stream	-Poorly defined -Lack of framing -Future problem	Financial, Political
Policy stream	-Technically complex -Missing key details -Highly unpopular	Financial, Ideological, Political, Public, Provider Choice
Politics stream	-Political risk aversion -Strong opposition -Timing not ideal	Political

Ultimately, each stream faced serious challenges, and 1Care did not have an adept policy entrepreneur at its helm to recognize potential windows of opportunity (Figure 16). However, as with most wholesale reforms, and evidenced by experience from numerous countries, transforming a health system towards mandatory social health insurance often requires multiple election and policy cycles before achieving success.

3.6 Discussion

The 1Care policy was a partially constructed technical solution, to a problem that was not yet a crisis, with significant ambiguity remaining in the detailed implementation of the policy. Deemed ‘arguably the most contentious issue in health in Malaysian society spanning three decades’, the proposal was not Malaysia’s first, and will likely not be the last, attempt to put national health insurance on the public agenda (Chee and Por 2015).

This chapter proposed a two-pronged analytical approach, first using Reich’s methodology to conduct a stakeholder analysis of 1Care, and then applying Kingdon’s multiple streams framework to assess the contextual policy factors that contributed to the reform’s failure. Both approaches point to the lack of political support by the Prime Minister and ruling coalition as fatal to the reform. The stakeholder analysis explores the interests at stake for BN, and why health care reform was not a high government priority. The multiple streams approach demonstrates how the policy was perceived to be a political liability, resulting in a political stream with very weak support from the ruling coalition.

3.6.1 Fundamental causes of 1Care’s failure

In response to the research question posed at the beginning of this analysis, I believe that lack of political support by the Prime Minister and ruling coalition was the underlying and fundamental cause of 1Care’s failure. Conversely, if the government had fully exercised its

political will to support 1Care, it is unlikely that the level of stakeholder opposition demonstrated in this case would have been sufficient to block the reform.

With that said, stakeholder opposition, particularly from political and financial interest groups, did play a role in influencing the government's decision to opt for a passive stance on 1Care. Many of the MOH officers interviewed by the MHSR research team pointed to the *TakNak* opposition campaign as a contributing factor to the reform's failure. The fact that the PM, Economic Council, and Cabinet had approved the 1Care concept in the initial stages means that there was a potential window for the reform to be pushed further.

SHI was conceived to provide sustainable healthcare in the future, in response to the constraint set by the MOF against increasing the budgetary allocation for health. Passing 1Care could conceivably have helped achieve the long-term goal of controlling escalating health care costs, in addition to reaping the economic benefits of reducing morbidity and improving health outcomes. Yet the perception of the MOF and other economic agencies remained that 'health is always seen as something that takes up the government budget and not a major contributor to the economy.' (MHSR Interview #11).

Without an ideological shift on the part of the Prime Minister and other senior economic policymakers, significant increases in budgetary allocations to the health sector was limited, constraining options for reform (Croke, Virk, and Almodovar-Diaz 2015). There was also a misconception that the government would immediately reduce its spending on health under 1Care. The concept paper estimated that government spending for health would increase from 2.11 percent of GDP in 2007 to an estimated 2.85 percent of GDP under 1Care. An interviewee described the MOF reaction: 'Even when we brought up 1Care, we said that we need to increase the health budget. We have had a series of workshops engaging different people in the workshop for financing there was an officer from the Ministry of Finance. I remember he said

that he thought that 1Care was going to save the government money and now 1Care is going to cost the government more money.’ (MHSR Interview #33).

Ultimately, health was not a major priority for the government or the public. PM Najib’s Government Transformation Programme (GTP), launched in 2010 as part of the vision towards high-income status, identified six National Key Results Areas based on extensive surveys and public engagement; corruption and economic concerns topped the list, while health was not among the areas identified for the program.¹²

3.6.2 Limitations

This study has several limitations. Conducting political analysis is often referred to as ‘an art as well as a science’ (Roberts et al. 2003b). By applying Reich’s stakeholder analysis approach and Kingdon’s multiple streams theory, I attempt a rigorous, scientific analysis using globally recognized methods; however, as a single case study of a specific reform attempt, this study cannot be generalized to similar reforms in other countries.

There are a multitude of actors with a stake in Malaysia’s health policy process. My analysis comprises more than fifty stakeholders, spanning seven different sectors, yet it would not be possible to include every stakeholder within the scope of this paper. For example, my initial list of professional associations alone numbered close to one hundred. It was necessary to cull the long list of stakeholders to those of greatest significance and/or those which played a more prominent role. This could potentially bias the analysis towards the more powerful and mobilized stakeholders. To address this limitation, I sought to identify non-mobilized groups to the extent possible, through the document search and interviews, by comparing my

¹² The six National Key Results Areas were: reducing crime, fighting corruption, improving student outcomes, raising living standards of low income households, improving rural basic infrastructure and improving urban public transport. A seventh area was added in 2011: addressing cost of living.

stakeholder list to those of other analyses, and based on my own observations made over the course of almost two years spent in Malaysia. I also reviewed the list of stakeholders with Malaysian counterparts with a deep understanding of the health system and policy, to ensure there were no glaring omissions.

The analysis is largely dependent on information from interviews – which reflect only what participants were willing to disclose – and data available from public sources – which indicate the resources stakeholders were willing to openly deploy. The analysis does not address negotiations that may have occurred behind closed doors. Malaysia’s heavy public investment in the private sector via GLICs and GLCs means that private entities have considerable access to the highest levels of public office, and may lobby accordingly. Gaining access to such information is particularly challenging in Malaysia, where the Official Secrets Act is cited on a regular basis in policy discussions between the government and stakeholders. For this reason, the analysis focuses on external stakeholders, and the discernable efforts they made to support or oppose 1Care.

Finally, Malaysia is a multi-ethnic, multi-lingual society; in addition to English, the predominant languages are Malay, Mandarin, and Tamil. With respect to public documents, websites, newspapers, and beyond, this analysis primarily reflects information available in English, and, to a lesser extent, Malay.

CHAPTER 4. RESULTS STATEMENT PART 2: APPLYING LESSONS FROM 1CARE TO CURRENT REFORM EFFORTS

4.1 Introduction

Although Malaysia has achieved strong performance in health outcomes and a relatively high level of financial risk protection, the sustainability of the health system is threatened by an over-reliance on out-of-pocket financing and rapidly rising health expenditures, driven in part by the largely unregulated private sector. With out-of-pocket spending accounting for almost 40 percent of total health expenditure, and the share of private health insurance almost doubling in the last two decades, there are important implications for the effective and efficient use of resources. To date, neither source of funding has been successfully directed towards cost containment or quality improvement of health services.

Malaysia's 1Care proposal to move from a National Health Service (NHS) model towards Social Health Insurance (SHI) sought to address these growing threats to the financial sustainability of the health system. With the failure of 1Care, and with limited potential of increasing the federal budgetary allocation to health, policy developers within the Ministry of Health had to explore alternative mechanisms to counteract the rapid increase in health spending and to organize the large amount of out-of-pocket spending.

Based on the trajectory of health financing and budgetary constraints, Malaysia will continue to rely on a mix of public and private financing and delivery. High out-of-pocket spending is not unique to Malaysia; in almost all developing countries, this source of financing constitutes a significant proportion of total health expenditure (World Health Organization 2018). However, most countries see a reduction in out-of-pocket spending concurrent with economic development. Potentially large gains in health outcomes and efficiency can be made by offering insurance to risk-averse consumers as an alternative to large out-of-pocket payments (Pauly et

al. 2006). The expansion of Malaysia's economy toward high-income status, and the growth in private health insurance – from 3.6 percent of total health expenditure in 1997 to 6.4 percent in 2015 – presents an opportunity for the government to attempt incremental reform (MNHA Unit 2017).

4.1.1 The VHI reform¹³

In July 2016, at a meeting convened by the World Bank on 'Building strong health systems to achieve universal health coverage,' Malaysia's Health Minister, Datuk Seri Dr S. Subramaniam announced the introduction of a government-linked, non-privatized, non-profit voluntary health insurance (VHI) scheme (Lau 2016). Although few details were provided, the Minister emphasized that the scheme would be entirely voluntary, would have 'no private player and no profit motive' and would address weaknesses in the private healthcare system (2016).

The initial reaction to this announcement was relatively muted, although opposition politicians were quick to warn against moving forward with the VHI scheme without engaging the public, citing the 'public backlash' against 1Care (*Malay Mail Online* 2016a). Interestingly, several policy analysts assumed VHI would be a national health insurance reform, and supported the idea as 'a game changer to catapult the Malaysian healthcare system into the 21st century' (Khalib 2017b).

One year later, Prime Minister Najib Tun Razak and his Cabinet approved the VHI concept and initial business plan, and the scheme was officially allocated RM 50 million (approximately USD 12.8 million) in the 2018 federal budget presented in October 2017 (*New Straits Times* 2017b).

¹³ For simplicity, I refer to the government-linked non-profit insurance scheme as 'VHI' throughout this document. When the general concept of voluntary health insurance is concerned, this will be clearly indicated in the text.

Voluntary health insurance poses several advantages, such as offering financial protection when compared to out-of-pocket spending and facilitating access to health services which are not provided in the public sector (Colombo and Tapay 2004).

Malaysia's VHI scheme may accomplish a number of objectives in the medium to longer-term, beginning with the mobilization of out-of-pocket expenditure into a more efficient, organized risk pool. Second, VHI would serve as a benchmark for the private health insurance (PHI) sector, putting downward pressure on insurance premiums in a primarily for-profit market operating under minimal regulation and oversight. The VHI scheme would enable the decongestion of public services by shifting demand toward the private sector, easing the burden on the currently overcrowded public hospitals. Implementing a VHI scheme would allow the government to experiment with innovations such as employing strategic purchasing to improve the efficiency and quality of health services.

Although still in the nascent stages of implementation, the VHI reform has the potential to build a foundation for many of the principles delineated by 1Care, such as equity, universality, inclusivity, effective coverage, financial protection, and the provision of an adequate benefits package. However, if VHI remains narrow in its scope, providing a limited product to a relatively small population, its impact on the health system will be minimal. If VHI is expected to lay the groundwork for future, larger-scale reforms, policymakers should consider political strategies at an early stage to ensure this transformation occurs and avoid a repetition of the 1Care experience.

4.1.2 Goal and structure of this chapter

Malaysia's VHI reform represents an incremental step towards a long-term vision of an efficient, equitable, and sustainable system of health financing. To avoid a similar fate as the 1Care proposal, and to increase the potential for successful implementation, particularly in the

longer-term, the political economy of the VHI reform should be carefully considered. Although the current scope of VHI varies significantly from that of 1Care, there are important parallels between the two reforms which have the potential to affect some of the same vested interest groups.

The previous chapter, Part I of the Results Statement, presented an in-depth stakeholder analysis of 1Care and offered conclusions about the fundamental cause of the reform's failure. This was largely due to a lack of strong political support from the highest levels of government. Whereas opponents of the reform mobilized their resources and power against 1Care, the government ultimately took a passive stance on the reform.

To provide relevance for the current environment, this chapter extracts lessons learned from 1Care to consider as the government implements VHI and proposes strategies to enable VHI to serve as a vehicle for longer-term, more comprehensive reform. This is achieved by first assessing the progress and scope of the reform to date and identifying whether any political strategies have been deployed by the Ministry of Health after the 1Care experience. Next, I identify commonalities across 1Care and VHI in terms of their policy goals, proposed mechanisms, political environment, and potential impact on stakeholder interests. Finally, I discuss the potential longer-term goals of VHI, and propose political strategies to achieve these goals. The analysis builds on the findings from Results Statement Part I.

The paper is organized as follows: Section 4.2 briefly summarizes the methodology applied for this analysis. Section 4.3 describes the VHI reform in detail, including an overview of Malaysia's current private health insurance system, and the goals, mechanisms, and timeline of the policy. Section 4.4 presents the results of the analysis, comparing the components of the 1Care and VHI reforms; identifying the interest groups that may be impacted by VHI, and comparing the policy environments of the two reforms using Kingdon's multiple streams

framework. Section 4.5 discusses how lessons learned from 1Care can be applied to VHI in the short term, as well as strategies to implement to lay the foundation for VHI to serve as a catalyst for an inclusive, equitable, and sustainable health system in the long term.

4.2 Methodology

4.2.1 Conceptual framework

This analysis references the same conceptual frameworks applied in Part I of the Results Statement, which are described in detail in Section 3.2.1.

In Part I, Reich's *Policymaker* approach to stakeholder analysis and political mapping was used to identify the power and position of stakeholders on the 1Care reform. This allowed for an in-depth analysis of the coalitions that formed in response to the policy and demonstrated how the opponents to the reform effectively used their power, in comparison to the proponents of the reform which did not effectively mobilise their significant power and resources. In this chapter, I apply the six-category typology of interests, derived from the 1Care analysis, to the VHI reform. The interests of the key players are analysed with respect to the VHI reform, to determine which players may win, lose, or have minimal impact due to the policy. I also assess how the Ministry of Health's approach to VHI differs in the wake of the experience with 1Care, and how this has an impact on the scope of the current policy.

Next, I compare the policy environment of 1Care with that of VHI, making reference to Kingdon's multiple streams approach (Kingdon 1995). The findings from Part I suggested critical shortcomings in the three required streams to present a window of opportunity for reform – problem, policy, and politics – which contributed to the failure of 1Care. Here, I discuss which aspects of the policy context have changed or remain the same, including timing of the election cycle, and the potential relevance for the VHI reform.

4.2.2 Data

As in the previous chapter, I relied on two sources of data for this analysis: document collection, and in-depth stakeholder interviews. First, I conducted a desk review of publicly available documents, beginning with the peer-reviewed literature, and then consulting the grey literature from policy analysts, NGOs, and think tanks, which comprised documents, reports, and research outside of traditional academic publishing. Next, I conducted a general web-based search of newspaper articles, blogs, press statements, and government publications relating to VHI.

The in-depth stakeholder interviews were conducted by a Harvard research team with the Malaysian Health Systems Research (MHSR) project, seeking to understand why comprehensive health system reform has failed in Malaysia over the last 30 years (Croke, Virk, and Almodovar-Diaz 2015). The research team interviewed 42 key stakeholders, including current and former Ministry of Health officials, other ministry and executive agency officials, health providers (private sector physicians, public sector physicians, and hospital managers), NGOs, international organizations, and business leaders (2015).

4.3 Non-profit VHI: where is it now?

4.3.1 Policy description

Voluntary health insurance is the vision of Malaysia's Health Minister, Datuk Seri Dr S. Subramaniam, conceptualized as a vehicle for incremental reform to lay the groundwork for a more equitable, sustainable health system. In announcing the VHI reform, Minister Subramaniam emphasized two aspects of the scheme: first, that it would be voluntary, and second, that it would offer an alternative form of health insurance to address weaknesses in the private healthcare system (Lau 2016). The Minister stressed that that government's

responsibility towards to the public health system would remain unchanged and cautioned that the scheme was still in the design phase and would be presented to the public only ‘once we are confident’ (2016). This emphasis on the voluntary nature of the reform is critical for several reasons, primarily in that it distinguishes the reform from 1Care and counters any potential backlash against mandatory enrollment, one of 1Care’s most controversial elements.

Unlike social health insurance, which is characterized by mandated enrollment and payment of wage-based premiums, voluntary health insurance is defined as any insurance where people independently decide to enroll and pay a premium (World Health Organization 2018). In many high-income countries, voluntary health insurance plays a supplementary or complementary role to publicly funded health services, particularly for wealthier citizens with disposable income and the expectation of better quality health services (2018). The level of compulsion is an important component of any health insurance scheme, as it determines the size and breadth of the risk pool, and may also be an indication of the importance policy makers assign to coverage (Gottret and Schieber 2006).

The fundamental role of health insurance is risk pooling, whereby groups or individuals contribute to a common pool of funds, which are then used to purchase a defined set of services for members of the pool based on their need. Health insurance mobilizes funds for health while pooling risks across persons in the population to mitigate financial risk. Risk pooling is necessary to address equity and financial sustainability in health, by redistributing prepaid resources to individuals with the greatest health service needs (Kutzin 2012).

As outlined in Table 9, Malaysia’s VHI reform has several important goals in the short to medium-term. While no definitive timeline has been established, these objectives would ideally be achieved within five to ten years of implementation. A primary objective of the reform is to mobilize the inefficient and unorganized out-of-pocket spending, which currently comprises a

large component of total health expenditure, into risk pooling arrangements. Whereas about one-third of Malaysians are covered by some form of health insurance, more than half of the population accesses private health services (NHMS 2015). Given the exclusionary and underwriting practices of for-profit private insurers, certain groups such as the elderly and disabled have no options for insurance coverage, even when they can afford it, and are forced to pay high out-of-pocket costs or seek care in the public sector (Ong 2017).

Table 9. Goals and mechanisms of VHI reform in the short to medium-term

Goal	Mechanisms
Mobilizing OOP	<ul style="list-style-type: none"> ▪ Mobilize the current high out-of-pocket spending into an organized financing vehicle to pool risks
Decongesting public services	<ul style="list-style-type: none"> ▪ Giving more affordable access to private health care services will shift demand towards the private sector
Serving as a benchmark for PHI market	<ul style="list-style-type: none"> ▪ Negotiating with providers and using strategic purchasing to purchase cost-effective services at competitive rates will put downward pressure on the PHI market premium rates
Improving efficiency and quality	<ul style="list-style-type: none"> ▪ Separation between provider, purchaser, and consumer ▪ Leveraging strategic purchasing and new provider payment mechanisms such as capitation to encourage high-quality, more efficient services

The VHI reform also seeks to address overcrowding in public hospitals, by offering an affordable option to access private services. If uptake of the health insurance is sufficiently large, it will decongest the public health facilities as an increasing proportion of patients seek care from private sector providers. VHI products could target specific services to achieve this objective – for example, 23 percent of government hospital admissions are due to pregnancy, and private coverage of antenatal care and pregnancy could provide considerable relief to the public sector (Ministry of Health, KKM Facts, 2017).

As a non-profit player in a heavily for-profit market, VHI is expected to serve as a much-needed benchmark for the PHI industry. In addition to high profit margins, PHI typically has high administrative costs; in Malaysia, the combined cost of management expenses and commissions is estimated to consume up to 25 percent of insurance premium revenues,

according to Bank Negara (Atun, Berman, Hsiao, et al. 2016). As the VHI will have no profit motive, high profit margins and excessive overhead costs will be unnecessary. By engaging in selective contracting of high quality health services, the VHI will ideally use its market power to extract reasonable costs from private and public providers, thereby allowing the scheme to offer premiums at competitive rates.

As market share of the non-profit VHI expands, innovative mechanisms such as strategic purchasing will be leveraged to drive systematic change across health care providers to improve quality, ensure appropriate services are provided, and promote cost containment and efficiency. Through this mechanism, the VHI could purchase cost-effective, high priority services, such targeting the prevention of costly diseases such as NCDs.

Strategic purchasing is a key component of the VHI reform and would propel the transformation of the delivery system from input-based budgeting towards contractual performance-based payment. The current provider payment mechanisms in place are primarily fee-for-service, which substantial evidence points to as cost-inflationary (Cutler 2002). VHI could be used as a tool to implement new payment mechanisms, such as capitation and diagnosis-related groups (DRGs), which would distribute some financial risk to providers, thereby encouraging greater efficiency. Strategic purchasing would also enable the adoption of quality improvement mechanisms such as provider accreditation.

These objectives will be carried out by a non-profit insurance company, which, while officially taking the form of a NGO, will remain under the purview of the MOH and guided by the vision of the Health Minister (Ong 2017). As such, the governance structure of the VHI company will be particularly important to ensure the non-profit, socially-oriented mission is maintained. The company is still in the process of being established, and few details have been released to the public with respect to its structure.

The VHI reform will be rolled out in phases, with products marketed to specific population groups. With a non-profit, socially oriented mandate, the VHI will ideally avoid common for-profit practices such as underwriting and opt for community-rated products. At the same time, the VHI scheme must remain financially solvent. As the reform is still in the early stages, these products remain largely in the conceptual phase. However, one population has already been delineated by the Ministry of Health for coverage under the VHI scheme: foreign migrant workers covered by a mandatory insurance scheme known as SPIKPA (*Skim Perlindungan Insurans Kesihatan Pekerja Asing*, or the Foreign Workers Hospitalization and Surgical Scheme).

Launched in 2011, the SPIKPA scheme provides basic cashless accident and illness inpatient coverage at MOH hospitals for non-professional (i.e. ‘blue collar’) foreign workers. Coverage under the scheme is a mandatory requirement for the provision of a work permit; the government stipulates the basic benefit package required, and a maximum threshold for the premium. Currently, twenty-five health insurers offer this product – all at the same maximum premium rate – with claims processing by third party administrators (TPAs). Under the reform, SPIKPA policy coverage will be phased into the new non-profit VHI entity, targeting a start date in mid-2018 (Khumaran 2017).

According to Health Minister Subramaniam, after the first phase targeting foreign workers, the VHI will target other as-yet unspecified groups, with the scheme growing ‘at a pace where we are comfortable and that will allow the success of the initiative’ (Khumaran 2017). The Minister further indicated that the government may offer targeted assistance to enroll certain population groups; although no public announcements have been made regarding the composition of these groups, likely candidates for the subsidies would be civil servants and low-income Malaysians (2017).

The VHI reform carries a number of important risks – both technical and political – that should be carefully considered by the government. Designing an insurance system is challenging and requires overcoming various economic obstacles, many of which relate to agency problems: insurers may be unable to compel relevant parties to do what efficiency requires (Hsiao and Shaw 2007). As is the case for any voluntary health insurance, the greatest financial risk is adverse selection, which can be fatal for insurers; moral hazard and supplier-induced demand represent additional risks (Morrisey 2008). Operating a socially conscious, non-profit, community-rated insurance scheme that provides coverage to previously under-served populations such as low-income Malaysians makes the VHI particularly susceptible to these risks.

The political risks of launching the VHI scheme are particularly important, given Malaysia's political context and history of patronage involving lucrative government contracts. The recent 1MDB political scandal, accusing PM Najib with mismanagement and personal appropriation of sovereign investment funds, has made the Malaysian public even more wary of paying into government schemes (Wright and Clark 2015). There are numerous opportunities for political interference and profit-making in the establishment of the VHI company – from the recruitment of executives to procurement of IT systems. Launching VHI before the necessary expertise has been identified and sufficient capacity has been built could result in the scheme's failure, eroding the public's trust in the government even further, and exposing the ruling coalition to political attacks from the opposition.

4.3.2 Timeline

At this writing, the VHI reform remains in the early stages of implementation, with very little information released to the public. Unlike 1Care's proposition to comprehensively transform the health system, the incremental nature of the VHI reform has enabled the Ministry of Health

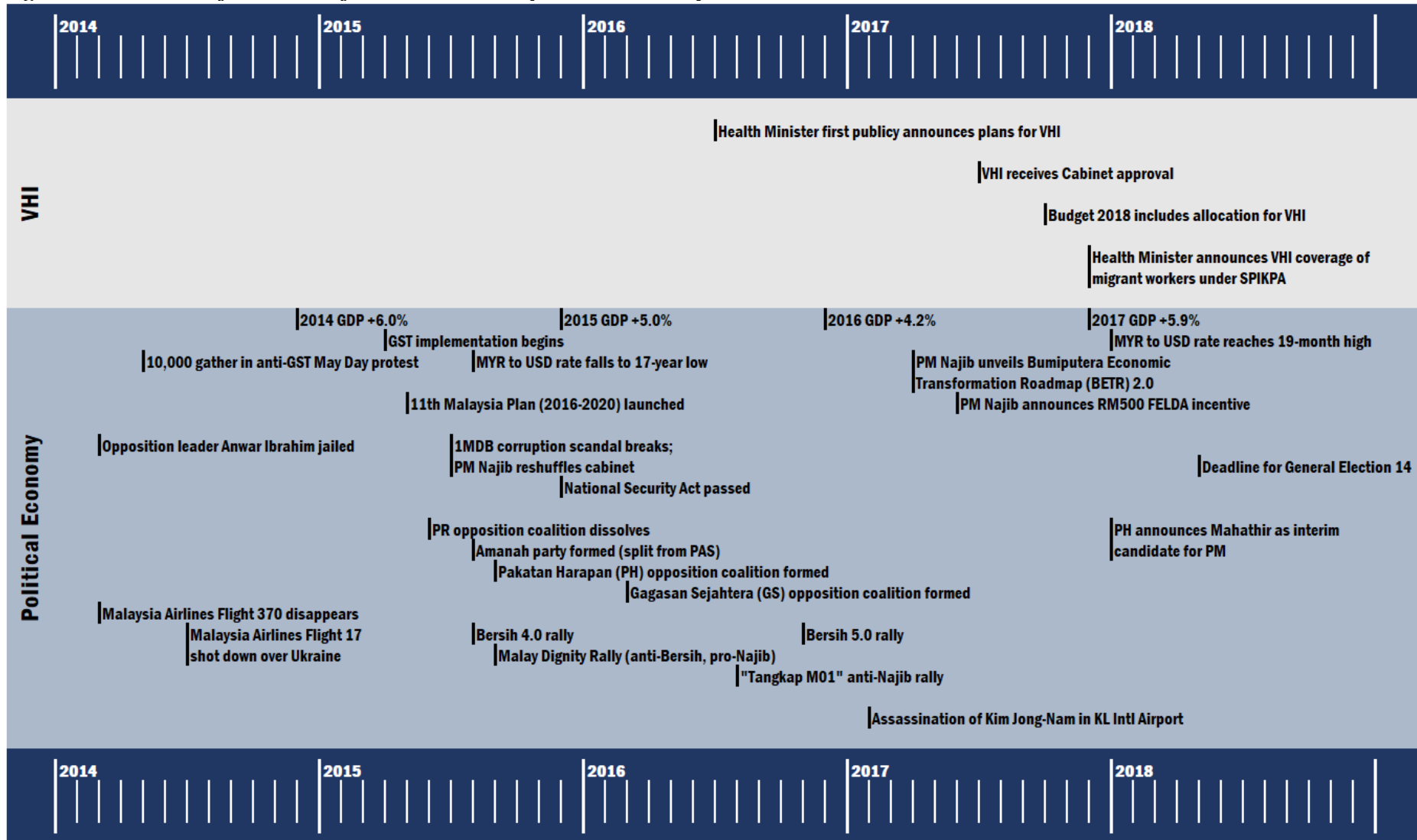
to take a more cautious approach. The initial public announcement of the reform was made, amidst little fanfare, by Health Minister Subramaniam in a July 2016 meeting of the Joint Learning Network convened by the World Bank (Lau 2016). Having granted initial approval of the VHI conceptual design in 2016, the Cabinet formally approved the VHI business plan and initial budget in July 2017. PM Najib's announcement of the 2018 Federal Budget included a RM 50 million allocation for VHI, to primarily fund start-up activities such as recruitment and capacity building, and enrollment of the first target population, foreign migrant workers under SPIKPA, to begin in mid-2018 (Khumaran 2017).

While the timeline of the VHI reform is still ongoing, there have been many important developments in Malaysia's political economy in the interim since the last general election in 2013 (Figure 17). Malaysia Airlines suffered two catastrophic events that gripped both the nation and the world: the disappearance in March 2014 of Flight 370 due to unknown circumstances, and, only four months later, the shooting down of Flight 17 by pro-Russian separatists as it passed over Ukraine. In February 2017, the country was yet again embroiled in global scandal with the assassination of Kim Jong-Nam at KL International Airport.

In July 2015, PM Najib became the central figure of what has been called 'Asia's biggest corruption scandal' – involving the country's sovereign investment fund, 1Malaysia Development Berhad (1MDB), created by Najib in 2009 to 'borrow money so it could attract investment and stimulate the economy' (Webb 2017). After 1MDB missed payments of USD 11 billion owed in debt to foreign investors in 2015, Malaysia's Attorney General uncovered evidence that USD 681 million had been transferred from the fund to Najib's personal accounts between March and May of 2013 (Wright and Clark 2015). The accusations prompted several international investigations, culminating most notably in the U.S. Department of Justice filing a lawsuit alleging at least US 3.5 billion had been stolen from the fund by Najib (unnamed in

the lawsuit but cited as ‘Malaysian Official number 1’), his family, and his associates (Teoh 2016).

Figure 17. Timeline of the VHI reform and relevant political economy context



PM Najib took swift action, starting with a reshuffle of the Cabinet to oust several of his detractors, including Deputy Prime Minister Tan Sri Muhyiddin Yassin, a vocal critic of the government's handling of the 1MDB probe (Teoh 2015). Citing health reasons, Najib also sacked Attorney General Tan Sri Abdul Gani Patail, who had led the initial investigation and was on the verge of filing charges on the 1MDB case (2015). Denying all accusations, the PM insisted that the US 681 million received in his bank account was a personal donation from the Saudi royal family; an assertion upheld by the parliamentary Public Accounts Committee investigating 1MDB, headed by the newly appointed Attorney General (Wright 2016).

Amidst calls for the PM's resignation by opposition parties and the public at rallies numbering in the hundreds of thousands, Najib further tightened his control over the country by pushing a controversial new bill through Parliament in December 2015. The National Security Act gave the government unprecedented powers, such as the ability to declare martial law in areas deemed to be a security threat, and allowing security forces sweeping powers of search, seizure, and arrest without warrant (*Al-Jazeera* 2016).

Meanwhile, there were dramatic shifts in the opposition political landscape. Pakatan Rakyat, the leading opposition coalition, dissolved due to disagreements between the Democratic Action Party (DAP) and the Pan-Malaysian Islamic Party (PAS) over the implementation of Shari'a law. PAS left to helm a 'third force' coalition known as Gagasan Sejahtera, loosely uniting opposition Islamist parties; only to be lured back into the UMNO fold when PM Najib endorsed a PAS call to implement and expand certain Sharia'a laws (*Malaysiakini* 2016b; Wong 2018).

Pakatan Harapan was formed as the successor to PR in September 2015, comprising the DAP, the People's Justice Party (PKR), the National Trust Party (AMANAH), and the Malaysian United Indigenous Party (PPBM) (*Malaysiakini* 2015). Founded by former PM Mahathir, the

PPBM party took direct aim at UMNO's core Malay constituency; the party leadership includes the ousted former Deputy Prime Minister Muhyiddin Yassin as its President, and Mahathir's son Mukhriz as its Deputy President.

Significant controversy surrounds the opposition's PM candidate for the upcoming 14th General Election. Anwar Ibrahim, founder of the PKR party and previously the de facto leader of the opposition coalition, was once the favored choice for Prime Minister. Previously a member of UMNO, Anwar had served as both Deputy Prime Minister and Finance Minister before he fell out of PM Mahathir's favor and was imprisoned in 1999 on sodomy and corruption charges. A second arrest in 2015 on similar charges was widely perceived as PM Najib's attempt to 'remove Anwar from Malaysia's political equation,' a move that backfired spectacularly as it produced 'one of the most unthinkable reconciliations in world's history between two nemeses: Anwar and Tun Dr Mahathir Mohamad' (Liew 2018).

In January 2018, Pakatan Harapan named 92-year-old Mahathir its candidate to head the government – a move alternatively touted as brilliant or a dereliction of the coalition's moral authority (Wong 2018). If Mahathir succeeds, he is expected to pave the way for an Anwar administration by extracting a royal pardon that would undo a ban prohibiting Anwar from holding office for five years after release (2018).

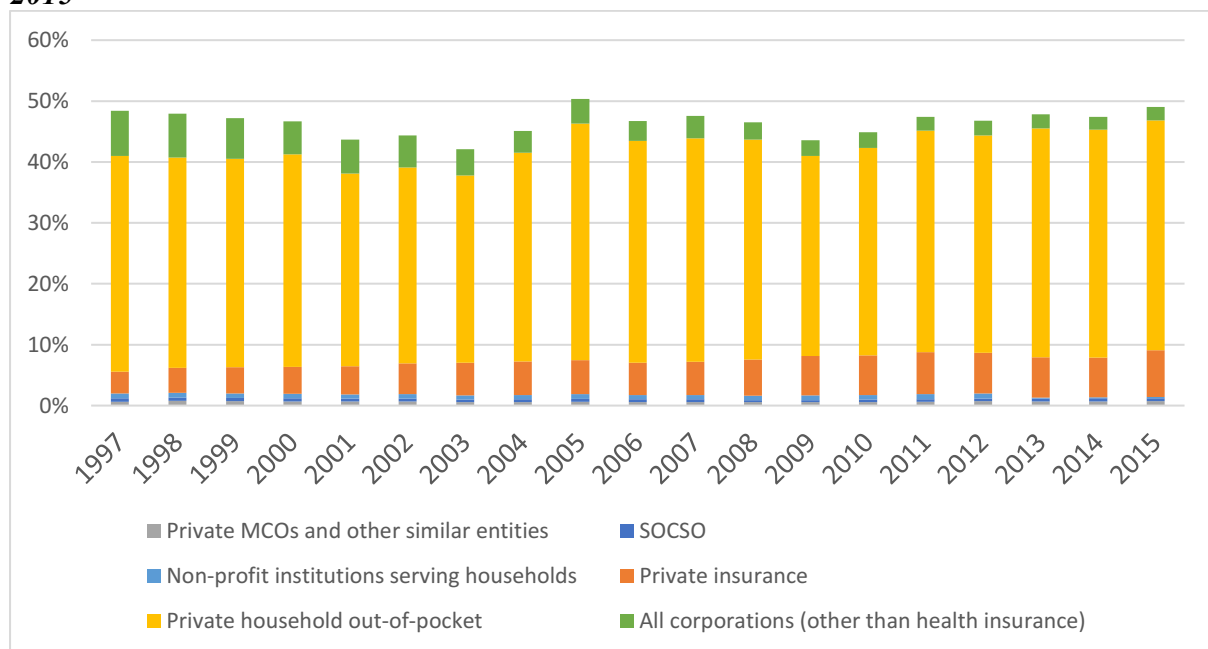
Malaysia's 13th Parliament will automatically dissolve in June 2018, making the deadline for elections in August of the same year. After being plagued by the 1MDB scandal, victory for Najib's Barisan Nasional in the election seemed inconceivable; yet conflict within Pakatan Harapan – including a faction calling to boycott the election due to dissatisfaction with Mahathir's candidacy – and PAS's rapprochement with UMNO have polls suggesting a comfortable win for Najib and even a return to two-thirds majority for BN (*The Malaysian Insight* 2018). The considerably strengthened performance of the Malaysian ringgit, and PM

Najib’s popular economic initiatives such as the second Bumiputra Economic Transformation Roadmap and cash incentives to the FELDA rural farmer program, may tip the balance of voter sentiment further in BN’s favor.

4.3.3 Overview of Malaysia’s PHI market

The government’s VHI reform will introduce a new player to the existing private health insurance market, which, while small, represents a growing proportion of health expenditure. Private health insurance alone increased from 3.56 percent of total health expenditure in 1997 to 7.70 percent in 2015; adding in health spending by private managed care organizations (MCOs) and corporations, this proportion increases to 10.60 percent in 2015 (Figure 18). With Malaysia’s continued economic growth, the demand for private healthcare, and in parallel, private health insurance, is expected to keep rising. Financial projections for Malaysia’s PHI industry indicate the market has considerable room to expand, with an estimated three-fold increase from US\$1.5 billion in 2010 to US\$5 billion by 2020 (Berger 2013).

Figure 18. Private sources of financing, as percentage of total health expenditure, 1997-2015



Source: Malaysia National Health Accounts 1997-2015 (MNHA Unit 2017)

Although PHI products have been available in the Malaysian market since the 1970s, it was not until the 1990s that the volume of sales began to increase, in large part driven by several government reforms, such as the introduction of personal income tax relief on the purchase of PHI policies in 1996, and the Life Insurance Act in 1997, which loosened restrictions on life insurers to sell health insurance (Bank Negara Malaysia 2002; Munir 2015). The earliest PHI products were primarily related to personal accident, workmen's compensation, and motor accident insurance; products expanded to more comprehensive offerings in the 2000s with growing demand from individuals and employers as medical benefits increasingly became an essential part of remuneration packages (Bank Negara Malaysia 2002).

Currently, Malaysia's PHI market is oligopolistic, with three insurance companies holding more than half the market share (Munir 2015). The industry is dominated by life insurance companies, holding almost two-thirds of the PHI market and primarily offering individual health insurance products as riders to life insurance policies (2015). General insurers hold less than 20 percent of market share and mainly provide group insurance products targeting the employer-sponsored insurance (ESI) market (2015). Other key players in the insurance market comprise insurance agents, brokers, and managed care organizations (MCOs), which take on a role as third party administrators.

The remaining market share is held by family takaful operators, which offer products compliant with Shari'a (Islamic law) that are based on mutual cooperation, are free from interest, gambling, and uncertainty, and which distribute underwriting profits across both policyholders and shareholders (Khan 2005). Takaful products are available to Muslims and non-Muslims alike, and represent an important and rapidly growing segment of the insurance market in Malaysia. In 2017, growth in takaful insurance outpaced that of conventional insurance – with

family and general takaful expanding by 7.5 percent and 5.9 percent respectively, compared to 5.2 percent and -1.8 percent for life and general insurance (Singh 2018).

According to the 2015 National Health and Morbidity Survey (NHMS), approximately one-third of Malaysians are covered by some form of individual private or employer-provided health insurance (NHMS 2015). Employer-sponsored insurance is taking on an increasingly important role; the total labor force was estimated at 14.9 million people in 2017, and government-linked companies are estimated to employ more than 5 percent of the working population (Department of Statistics Malaysia, 2017). Despite the growing trend, the prevalence of ESI in Malaysia remains relatively low, with an estimated 8 percent of private employees covered, especially in comparison to high-income countries where employers are the predominant providers of private insurance (*Business Insider* 2014).

Regulation of insurance companies is overseen through Malaysia's Central Bank, or Bank Negara Malaysia (BNM), as stipulated by the Financial Services Act of 2013. These regulations primarily focus on financial solvency, such as stipulating minimum capital and risk-based capital requirements, but do not place significant limits on premium rates or common practices such as underwriting and risk-rating (Bank Negara Malaysia 2016). As a result, PHI products in Malaysia typically have stringent eligibility criteria and are highly risk rated, with variable premiums charged based on the policy holder's age, gender, smoking and health status, and occupational risk class (Munir 2015).

4.4 Comparison of 1Care and VHI: policy content, impact on stakeholder interests, and government strategy

4.4.1 Comparing the policy content of the 1Care and VHI reforms

Table 10 shows a comparison between the current healthcare system, the 1Care reform, and VHI, with regards to the key components of the health system.

A critical difference between 1Care and VHI is that the former proposed a major transformation of the financing, delivery, and governance of the health system, while the latter opts for a much more moderate, incremental reform. There are advantages and drawbacks to each approach. Proponents of incremental health system reform point to small but pragmatic steps to achieving universal coverage as being more politically feasible, dismissing wide-sweeping national health insurance reforms as ‘a hopeless home run swing when a bunt would do’ (Himmelstein and Woolhandler 2008, p103). Yet expansion of coverage requires additional infusion of money into the system, or the diversion of resources from elsewhere; incremental strategies that are geared towards underserved populations such as the poor who wield little power may be less politically expedient (2008).

In the case of Malaysia, the VHI reform primarily seeks to channel existing resources, notably the large out-of-pocket expenditure, towards more efficient risk pooling; the scheme is also expected to provide a less expensive alternative to consumers already purchasing private health insurance (*Malay Mail Online* 2017). The voluntary aspect of VHI is another important distinction from 1Care, which would have required mandatory enrollment. Although the first product VHI will offer is the mandatory insurance coverage for foreign workers, the subsequent offerings will expand into the group and individual markets, competing against other private insurers. Health Minister Subramaniam hinted at possible government assistance to enroll select populations in the VHI, which would require additional funds to be allocated for subsidies; these have not yet been stipulated but may likely target civil servants and low-income groups (Khumaran 2017).

Table 10. Comparison of current system, 1Care reform, and VHI reform

	Current System	Under 1Care	Non-profit VHI
Financing	<ul style="list-style-type: none"> ▪ General tax funding for public health system ▪ Private health services paid out-of-pocket or through private insurance ▪ Nominal registration fee (RM1 or RM5) 	<ul style="list-style-type: none"> ▪ Mandatory SHI enrollment at a fixed premium (contribution from employer and employee, govt) (rate unspecified) ▪ General tax funding for new public services ▪ OOP and PHI for top-up ▪ Co-payments (rate unspecified) 	<ul style="list-style-type: none"> ▪ Voluntary premiums for most groups and individuals ▪ Mandatory enrollment for foreign workers under SPIKPA ▪ Potential government subsidy for select target groups (i.e. civil servants, low-income)
Delivery	<ul style="list-style-type: none"> ▪ Two-tiered public and private system ▪ Private wards in some public hospitals (FPP) 	<ul style="list-style-type: none"> ▪ Horizontal integration of public and private providers ▪ Vertical integration between levels of care with family doctor gatekeeper system 	<ul style="list-style-type: none"> ▪ Maintains current delivery system; however, market forces and strategic purchasing + PPM may lead to changes over time
Purchasing	<ul style="list-style-type: none"> ▪ No separation of purchasing and provision function in public ▪ Private health insurers and MCOs purchase from private sector 	<ul style="list-style-type: none"> ▪ Separation of regulator-purchaser-provider functions, creation of autonomous NHFA, MHDS ▪ Strategic purchasing of standard benefits package 	<ul style="list-style-type: none"> ▪ Separation of purchasing and provision functions ▪ Strategic purchasing with public and private providers (dependent on sufficient market share)
Dispensing and prescription	<ul style="list-style-type: none"> ▪ Separated at government and private hospitals ▪ GPs and small clinics provide both functions 	<ul style="list-style-type: none"> ▪ Separate at all levels; only pharmacists will be able to dispense drugs 	<ul style="list-style-type: none"> ▪ Maintains current dispensing and prescription (note new Pharmacy Bill will not include D/S)
Referral system	<ul style="list-style-type: none"> ▪ Government hospitals require referral letter for specialists ▪ Private hospitals have no requirements other than ability to pay 	<ul style="list-style-type: none"> ▪ Family doctor serves as gatekeeper referral system 	<ul style="list-style-type: none"> ▪ To be determined
Supply-side control	<ul style="list-style-type: none"> ▪ Public sector - none (fee-for-service) ▪ Private sector – some control by insurers / MCOs 	<ul style="list-style-type: none"> ▪ Provider payment mechanisms – capitation, DRGs 	<ul style="list-style-type: none"> ▪ Potential to introduce provider payment mechanisms – capitation, DRGs ▪ Potential to increase autonomy for public providers
Demand-side control	<ul style="list-style-type: none"> ▪ Public – referral system ▪ Private – coverage limits, caps, by insurers / MCOs 	<ul style="list-style-type: none"> ▪ Co-payments ▪ Gatekeeper system 	<ul style="list-style-type: none"> ▪ Co-payments ▪ Incentives (i.e. reduced premium) for prevention and healthy lifestyle

Whereas the 1Care reform proposed to overhaul the delivery system, the VHI reform will work within the existing system, purchasing services from both public and private providers. The short-term implementation of VHI is not anticipated to drastically alter the health system; however, if successful at gaining a significant portion of market share, VHI has the potential to serve as a catalyst for change in the longer-term. These changes may be enhanced with complementary government interventions.

For example, the government has proposed grants towards the private sector and NGOs to operate non-profit charitable hospitals that would charge government hospital rates (*Malay Mail Online* 2016b). The VHI scheme could negotiate with these facilities to purchase cost-effective services while ensuring they receive adequate patient volume. With VHI increasing access to the private sector for lower-income groups, general practitioners, which currently face shortages in patients, may have greater incentive to operate in rural and under-served areas, and could consider forming networks to negotiate and contract with the VHI.

Like 1Care, the VHI reform seeks to create a separate function that will allow strategic purchasing of cost-effective services from both public and private sectors. However, the scale varies considerably – whereas 1Care would have mandatory coverage, VHI will need to compete for market share with existing insurers. If the VHI is unable to successfully offer attractive products and capture a significant segment of the market, its share will not expand much beyond the mandated foreign worker scheme, and it will have little leverage with which to negotiate with providers.

Another contentious issue under 1Care was its proposal to separate dispensing and provision, drawing strong opposition from GPs, which rely on prescriptions as a major source of revenue (*Malaysiakini* 2017). The VHI reform does not propose changes to the existing system, and the status quo will be reinforced by an upcoming Pharmacy Bill currently awaiting approval by the

Attorney General's office before being presented to Parliament (*Malaysiakini* 2017). The bill will allow patients the choice of where to purchase medicine, a move supported by a number of key players including GP associations, the Malaysian Medical Association (MMA), and the Federation of Malaysian Consumers Association (FOMCA) (Augustin 2017).

VHI has the potential to introduce several important supply-side and demand-side controls. Given the high risk of adverse selection for voluntary insurance schemes, these controls would serve a critical role to ensure appropriate service provision while maintaining high quality and preventing cost escalation. On the demand-side, VHI can structure its products to place controls such as co-payments and referral networks to reduce excess demand; it can also incentivize policyholders towards cost-effective preventive services by offering premium rebates for participation in wellness programs.

On the supply-side, VHI could offer new provider payment mechanisms (PPMs) such as capitation and diagnosis-related groups (DRGs) to both public and private providers, which currently operate primarily on input-based budgets and fee-for-service reimbursements. An element of performance-based payment could be included to encourage providers' meet quality standards. Introducing these mechanisms would optimally occur when VHI has sufficient internal capacity and market power to negotiate with providers; they may not be feasible in the immediate short-term but should be a goal for the medium and longer-term.

As only one product for VHI has been determined at this point – the basic hospitalization package for foreign migrant workers – many components of the reform will remain in the conceptual phase for the foreseeable future. Unlike 1Care, VHI will need to fight to achieve sufficient market power to provoke changes in the health system. Although a non-profit, the scheme must still generate enough revenue to cover its operations and risk-based capitalization needs, and surplus to expand its offerings. If VHI is unable to compete within the existing PHI

market, it may be doomed to operate at a reduced level, covering only the SPIKPA package, or may be required to fold its operations entirely.

4.4.2 The potential impact of VHI on stakeholder interests

Few details of the scheme have been released publicly, and VHI remains in the very early start-up stage, with only a single product to be offered in the short-term. The VHI announcement received overall neutral coverage by mainstream media outlets and has even drawn support from some policy analysts. A prominent opposition Member of Parliament and general manager of a leading research institute cautiously supported the scheme, stating that ‘if such a move can control healthcare costs, increase accessibility and protect Malaysians from catastrophic health events, then we should welcome it’ (Ong 2017). A widely read columnist and policy analyst went even further: ‘selling the idea of a national health insurance scheme to the Malaysian public is going to be tough and unpopular, even if it is voluntary. But it must be done. It cannot be delayed any longer’ (Khalib 2017a).

There has been minimal public opposition to the VHI reform to date; with its narrow scope, the reform was designed to preclude resistance from powerful stakeholder groups. As a voluntary scheme that in large part upholds the status quo, there are no major ‘losers’ touched by the reform.

Part I of the Results Statement identified six major types of stakeholder interests impacted by the 1Care reform: financial, political partisanship, bureaucratic, ideological, consumer interest, and provider choice and quality. In this section, I apply the same typology to assess the potential impact of VHI on these interest groups. The degree to which stakeholder interests will be affected by VHI is largely dependent on its scope. As VHI gains market power, its ability to impose conditions and negotiate prices with providers will increase.

Bureaucratic interests

In the immediate-term, the major challenge to VHI has been posed by actors within the bureaucracy, rather than by external stakeholders. Bureaucratic roadblocks – both within the MOH and between other ministries and agencies – were frequently cited in the MHSR interviews as a barrier to reform. Civil servants in administrative roles were perceived to be overly process-oriented and disincentivized against taking risks or pushing for innovative policies (MHSR Interview #8).

One interviewee described the frustrations of working with the Treasury:

‘Even at the ministerial level, at the minister’s level, you know, they still say, “Well, these are our instructions. These are our treasury instructions. These are our procedures and processes.” Even though when we tried to bring them in from the very beginning, hoping that they will be able to advise us on how to overcome these barriers, but I seemed to be getting the impression that they are there just to tell us, “No, you can’t do it this way” and they don’t want to tell us how can we do it’ (MHSR Interview #8).

Although the scope of VHI is considerably limited in comparison to that of SHI, the reform will nevertheless provide ample opportunity for bureaucrats to exercise their administrative power. It is anticipated that the VHI, although operated through a non-governmental organization, will maintain linkages to the Ministry to ensure the appropriate execution of its mission and vision. The establishment of a company to run the VHI scheme will have a multitude of administrative and logistical needs, from procuring services to hiring executive staff to selecting a location for the company headquarters.

Like 1Care, the VHI scheme has already received support from the PM, Economic Council, and Cabinet; its start-up budget and initial business plan were approved, theoretically paving the way for VHI to operate freely within these lines. Yet despite receiving the green light from the highest political levels, VHI has been subject to delays in implementation. As the holder of the purse-strings, bureaucrats within the MOF have considerable space to exercise their authority.

Within the MOH, there are also bureaucratic tensions between administrative and technical units. This was reflected by a technical officer within the MOH:

‘As technical people, we think that the administrative side should be able to help us, you know, overcome some of the bureaucracies of government mechanism. ... As the technical person, I get a little bit disheartened that that sort of mechanism cannot be worked out. But, we don’t have the backing of our administrative side who are actually a very important side because in the end, no matter what the vision, what the political masters want, it cannot be translated into practice, so it’s like policy and implementation, right? You can have the best policies, but the implementation issues derail you’ (MHSR Interview #5).

Financial interests

Policy research points to increasing resistance from health care professionals towards government policies, arising due to skepticism of the policy’s value for their patients or the health system, or for personal reasons such as worsening working conditions and reduced income (Tummers and Van de Walle 2012). As evidenced by 1Care, stakeholders which stand to lose considerable financial interests are typically amongst the most vocal and mobilized opponents to reform. The public campaign against 1Care was led by the Citizens’ Healthcare Coalition (CHC), primarily driven by the Federation of Private Medical Practitioners’ Association of Malaysia (FPMPAM).

Private physicians’ groups opposed 1Care’s provisions to separate dispensing and prescription, to require a family doctor gatekeeping system, and to change provider payment mechanisms. The possibility of VHI implementing new PPMs, therefore, could once again incite resistance from this critical stakeholder group. Several countries implementing DRGs have experienced physician opposition, for example, in the U.S., due to concerns over ethics and implementation-related issues (Thibadoux, Scheidt, and Luckey 2007); and in the Netherlands, due to widespread beliefs that DRGs neither contribute to care quality nor control costs (Tummers and Van de Walle 2012). A voluntary pay for performance scheme in France had less than two-

thirds uptake amongst physicians, citing concerns over ethical risks of the scheme (Saint-Lary et al. 2013). In the absence of government regulation of provider payment, VHI's ability to negotiate new PPMs with providers will depend on its market share; without adequate power it is unlikely that the scheme will have enough leverage to convince physicians to make the change.

The financial interests of private hospitals will come into play when the VHI scheme attempts to conduct strategic purchasing and negotiates prices with hospitals. The outcome of this process will largely be dependent on the VHI's ability to capture market share. Global experience has shown that very large buyers, such as government programs, may extract great discounts from providers, whereas smaller insurers, in order to bargain successfully, need to demonstrate strong patient-channeling ability and form more exclusive networks (Wu 2009). Hospital prices on average decrease in the presence of high insurer competition; however, there is evidence that the most attractive hospitals wield considerable bargaining power as insurers compete to include them in their networks, allowing them to negotiate very favorable terms (Ho and Lee 2013).

Another stakeholder group with financial interests that may be threatened by the VHI reform is the private health insurance industry. Competition from a new player in the PHI market is an expected occurrence, but if the VHI scheme receives preferential treatment from the government, the industry may cry foul and appeal to the regulating agency, Bank Negara Malaysia. A mandate for VHI to take over all new policies for the migrant worker SPIKPA scheme will result in a loss of business for the twenty-five insurers currently selling the product. There will need to be a strong justification offered by the government for the VHI scheme to take over this population, as opposed to competing against the existing insurers in an open market.

Political partisanship

As the deadline for Malaysia's 14th General Election draws closer, rhetoric from both the ruling and opposition coalitions has intensified; as with previous elections, economic concerns and political corruption top the agenda, with healthcare trailing behind.

The opposition Pakatan Harapan coalition has released its election manifesto, notably pledging to abolish GST and highway tolls, reintroduce fuel subsidies, provide more affordable housing, and to limit the Prime Minister to two terms, while also prohibiting simultaneously holding the position of Finance Minister (Kumar 2018). With regards to health, Harapan pledged to double the budgetary health allocation to 4 percent of GDP and to provide an annual RM500 subsidy to lower-income families for private clinic visits. Naturally, the manifesto neglected to mention how the government would afford such initiatives whilst simultaneously abolishing GST, provoking criticism of the opposition selling a 'far-fetched dream' (*Daily Express* 2017). The manifesto did not specifically address the VHI reform, although opposition MPs had previously called on the government to obtain industry and stakeholder feedback before proceeding with the scheme, to avoid a similar rejection that befell 1Care (*Malay Mail Online* 2016a).

Barisan Nasional has yet to release its election manifesto, but it is doubtful that VHI specifically, or healthcare in general, will feature prominently in the coalition's election pledge. The VHI scheme is still in the incipient phase and has been allocated a relatively small budget of RM 50 million in the 2018 budget; for now, its voluntary nature, and its scale and scope limit its use as a political tool either in favor or against the ruling coalition.

Ideological interests

Stakeholders with an ideological interest in health care reform are primarily rooted in Malaysia's academia and civil society. As discussed at length in previous sections, the

country's history of privatizing health care has been met with strong opposition from these groups in the past, culminating in the formation of the Coalition Against Health Care Privatization (CAHCP), a grouping of 81 NGOs, academics, consumer groups, trade unions, and the Socialist Party of Malaysia.

When the CAHCP mobilized against 1Care, members voiced concern about the government's conflict of interest between pursuing the public good and promoting the interests of the private healthcare provider industry. A government-established private health insurance company, albeit non-profit, could elicit similar concerns, particularly if VHI's appointing of executives and procurement procedures lack transparency and accountability. If the VHI is perceived to be yet another vehicle for government cronyism this will undoubtedly be seized upon by groups such as the CAHCP.

Yet there may be some alignment between the long-term goals for VHI and the desires of ideological groups. In its 'People's Health Manifesto', the CAHCP specifically called for cost containment measures, changing provider payment mechanisms, and the establishment of a comprehensive basic package of health services under national health insurance – offering some potential areas of overlap with VHI.

Much of the ideological opposition to 1Care was based on the belief in the government's responsibility to provide equitable and adequate health services to its people. In announcing VHI, the Health Minister was careful to reiterate that the government would maintain its role in the highly subsidized public system (Lau 2016). Health policy analysts have speculated that the government-run scheme could put pressure to negotiate cost controls and lower charges with private hospitals, thereby improving prospects for both the government and the insured (Ong 2017). If the VHI scheme is successful in achieving its goals to increase patients' access to healthcare, while maintaining its non-profit, socially motivated mission, and ensuring

transparent systems are in place, this may allay some of the concerns raised by ideological groups.

Consumer protection interests

Consumer associations rejected 1Care claiming it would increase taxes while limiting consumer choice; claiming that high administrative costs would be passed on to consumers while lucrative procurements were doled out to government cronies. As described above, if the VHI reform achieves its goals, consumer choice and interests should improve; in that respect, consumer associations should consider the scheme a positive development.

Nonetheless, consumer groups such as the Consumer Association of Penang (CAP) and the Federation of Malaysians Consumers Associations (FOMCA) are members of the CAHCP, and as such will likely keep a close watch on the VHI scheme for potential mismanagement of resources, questionable procurement practices, and any decreases in quality of service delivery. If the VHI achieves its objectives and maintains transparency, it would be expected that public interest groups will not oppose the scheme.

Provider choice and quality interests

Consumers are the primary interest group concerned with maintaining or improving provider choice and quality. This overlaps with their financial interests, as the consumer will invariably want better products at lower prices. The VHI scheme seeks to achieve exactly this goal – expanding health insurance access to the private sector at competitive premium rates (*Malay Mail Online* 2017). The Health Minister has been careful to cultivate a public narrative that the primary goal of VHI is to help people handle the high cost of private medical treatment.

The scheme will be voluntary, giving consumers a choice in whether to enroll; the VHI will need to offer attractive products to entice existing policyholders from their current insurers and

to convince first-time consumers that purchasing private health insurance is a worthwhile investment. With a large enough market share, the VHI scheme can place downward pressure on the PHI market, forcing competing insurers to lower premiums and offer better products. Furthermore, if the VHI can successfully create a large enough risk pool to cover insurance for higher-risk consumers such as the elderly and disabled, which currently do not have options for PHI coverage enough if they are willing to pay, this will considerably enhance consumer interests.

Malaysians view the subsisted public system as their fundamental right and the responsibility of their government; this is not anticipated to change under the VHI reform. Combined with the expected improvement in their options for accessing private health insurance, and barring any corruption scandals within VHI, consumers in general should be unlikely to strongly oppose the scheme.

4.4.3 Comparison of policy context using Kingdon's multiple streams approach

As discussed in Part I of the Results Statement, in the case of 1Care, the problem, policy, and political streams faced considerable challenges, in large part due to a lack of political support and the absence of a dedicated policy entrepreneur who could recognize the timing to create a window of opportunity.

The Health Minister at the time of 1Care, Liow Tiong Lai, played a passive role in the reform, VHI has a dedicated and ambitious policy champion in the form of Health Minister Subramaniam, who originally conceived of the idea of offering non-profit VHI. A dermatologist by training, and serving as Health Minister since 2013, Subramaniam is the president of the Malaysian Indian Congress (MIC), a key component party of Barisan Nasional. From his early experience as a house officer to his tenure as president of a state branch of the Malaysian Medical Association, the Minister has developed a reputation as a trusted, respected

leader in the medical community. Subramaniam's in-depth technical understanding of the health system's challenges combined with political savvy in navigating the political system make him an ideal policy champion for the VHI reform.

1Care suffered due to insufficient problem framing, which is a critical precursor to drive policy change and requires close attention by policy entrepreneurs (Mintrom and Luetjens 2017). The problem definition lays the groundwork for the policy proposal, and must be compelling enough to garner public interest over competing issues (Roberts et al. 2003b). Whereas 1Care policymakers were unsuccessful at defining a clear and compelling problem that would necessitate a move towards SHI, the VHI reform presents the problem in clearer terms: private insurance and health care are expensive; non-profit VHI will address this by providing high-quality products at lower prices.

Framing the problem in this way makes the policy proposal of VHI a logical solution that should be reasonably palatable to the public. Early opinions from health policy analysts have cautiously welcomed the scheme as a necessary step towards implementing cost containment measures and greater inclusivity in the PHI market (Ong 2017). The Health Minister's emphasis on the voluntary nature of the scheme, and repeated assurances that the government subsidized public health system will remain unchanged, address the public's major concerns about the 1Care proposal. In presenting the problem and policy, there is a deliberate effort by the Ministry of Health to distance this reform from 1Care. The Minister's insistence that VHI will have 'no private player and no profit motive' also speaks to the distrust in government-managed funds after scandals such as 1MDB.

Despite this positive initial development, the policy stream remains vague and will eventually need to be clarified in greater detail to engage with stakeholders and rally support for the reform. The current paucity of detail about the VHI reform, and the general lack of transparency

and trust in the motives of the government due to past experiences, make it difficult to have an ‘honest and rational debate on a complicated by very important part of public policy’ (Ong 2017).

With regards to the political stream, as discussed in Section 4.4.2, it is unlikely that the VHI reform will create a significant impact in the upcoming general election. The initial budgetary allocation for the VHI’s start-up has already been announced in the 2018 Federal Budget, with very minimal reaction from the public and stakeholders. Unlike 1Care which proposed a wholesale reform that would have a significant and immediate impact on the entire population, the VHI reform is a small-scale, non-mandatory effort that would be an easier ‘sell’ to the public. Framing the problem through the lens of the high cost of private healthcare makes it difficult for the opposition coalition to contest the issue, especially when Harapan has also pledged to defray costs of private healthcare in its election manifesto.

Despite the scandals plaguing PM Najib and his administration, and the strong performance of the opposition in the last election, the current internal squabbling within Harapan and its lack of a clear narrative have considerably diminished the credibility of the coalition. As one political analyst described it, ‘to claim that the opposition is in disarray is an understatement; the opposition looks to be a coalition of petty fiefdoms existing in an alternate universe where merely belonging in the opposition washes away the sins of the past’ (Thayaparan 2017).

4.4.4 Comparing the government strategy for VHI vs 1Care

As this chapter has emphasized, by pursuing an incremental reform with a very limited scope, the Ministry of Health has avoided taking on the risks associated with a large-scale reform like 1Care. Rather than apply lessons learned from the 1Care experience and strategically building the necessary political support to implement major reform, the MOH has opted for a very conservative approach. The need to address weaknesses in strategic communication that

occurred with 1Care have been largely circumvented by the design of VHI, which in its present form does not require considerable engagement with stakeholders. In short, the government has adopted a risk avoidance strategy, which may facilitate VHI implementation in the short-term, but could have negative ramifications in the longer-term.

In his announcement of the VHI coverage of foreign migrant workers, Minister Subramaniam described the subsequent phases for VHI in vague terms, stating that ‘the scheme has to evolve naturally and we hope our intentions will be achieved through this natural evolution’ (Khumaran 2017). However, there is a risk of adopting such a laissez-faire approach: without strong leadership and strategic action taken to achieve longer-term goals, VHI could further exacerbate the gap between well-financed private services available to those with the ability to pay, and lower-quality public services for the poorer population.

Establishing VHI may be an important incremental step towards health system transformation but will not invariably lead towards the attainment of a sustainable, equitable, and efficient system. While VHI is expected to serve the public interest, encouraging competition and creating a benchmark for the PHI market, this does not necessarily promote greater equity, especially if important segments of the population, such as the poor, are not included in the scheme.

Including the poor at the outset, via a targeted government subsidy, would be particularly important to establish principles of equity, solidarity, and social protection within the scheme. In addition, this would facilitate the establishment of a reasonably sized, sustainable benefit package that would create the foundation for a minimum or adequate package under for social health insurance. If low-income Malaysians are not included early on, and if more affluent or politically connected groups such as civil servants are prioritized and offered generous benefit packages, there is a strong risk of VHI legitimizing a two-tiered, inequitable system.

4.5 Discussion: lessons learned from 1Care and long-term strategies for VHI

4.5.1 Lessons learned and short-term strategies for VHI

Based on the comparison of the two reforms, a number of lessons from 1Care have emerged that can be applied to the VHI reform. These lessons should be translated into strategies for the MOH policymakers to adopt to achieve short-term objectives for VHI, as well as to pave the way towards longer-term goals to achieve a sustainable, equitable health system.

Framing the problem is a critical precursor to reform.

1Care provided insufficient justification to stakeholders and the public for a full-scale transformation of the health system. Lenin purportedly observed that ‘the worse, the better’ – astutely reflecting that the worse people’s conditions, the better the chances of revolutionary reform. Malaysians did not feel that the health care system was in critical enough condition to warrant its complete overhaul. Nor could health policy compete with the prevailing issues of the day – the economy, rising oil prices, and government corruption.

Short of tripling public hospital ward charges or adopting other draconian measures, the government must make a compelling case to rally public opinion on health reform. Whether this occurs by capitalizing on a national emergency, such as a flu epidemic, or by accumulating small-scale problems until they reach a critical mass, policy entrepreneurs should be adept at recognizing how and when to frame the problem.

In the case of VHI, the problem has been framed around the weaknesses of the current private healthcare system – specifically the high costs of private care and exclusionary practices of private insurers. This problem statement should resonate with many Malaysian citizens, as more than half of the population accesses private services, and out-of-pocket payments constitute almost 40 percent of total health expenditure.

Short and medium-term goals for VHI are to capture enough market share to give it the power to conduct strategic purchasing, serve as a benchmark for the PHI market, and lower prices while remaining solvent. As the details of VHI's product offerings become clearer and expand to further populations, the Ministry of Health should continue to frame the problem and set the agenda in a way that points to VHI as an optimal solution. For example, when PHI premiums inevitably rise – in 2017, insurers reported annual increases of 12 to 15 percent – there should be a communication strategy in place to enforce the messaging on high costs of for-profit insurance.

The policy solution should be clearly laid out, justifiable in relation to the problem, and strategically communicated.

Because the government did not adequately conduct strategic communication around 1Care, the policy was vulnerable to attacks from opponents, who exploited every omission and uncertainty of the proposal to their advantage. The issue of Malaysia's relatively low spending on health was not adequately addressed by 1Care policymakers. Opponents questioned why increasing the overall budget allocation to health, either through general taxation or increasing point-of-service payments, was not explored as a viable reform option. Lack of public debate and strategic communication process on this alternative solution proved a contentious sticking point for stakeholders.

Thus far, the VHI reform has been communicated to the public and stakeholders in broad terms; because there will not be an immediate effect on most stakeholders, other than those involved in providing SPIKPA coverage to migrant workers, there has not been a need to conduct much stakeholder engagement. However, as more products are added to VHI's offerings, there should be strategic communication to the populations being targeted.

In order for the public and companies to purchase individual and group policies from VHI, they will need to be convinced in the product, and have faith in the newly launched insurance company with relatively no track record. Transparency and accountability will be critical to gaining this trust, particularly in the wake of the 1MDB scandal and a slew of accusations of corruption and mismanagement of other government funds (Ling 2018).

As the company is set up, the government should seek to present the VHI as a socially responsible company that will not be a source of political patronage. For example, the executives and board selection will signal the government's intentions: if a known political crony is given the CEO position, this will likely reflect poorly on the VHI's mission. If the board includes respected members from civil society or consumer protection agencies, this will enhance the image of the company as pursuing social welfare.

Stakeholders should be strategically engaged by leveraging their interests.

Managing the short-term, concentrated costs of powerful interest groups is a fundamental necessity to successful reform; yet 1Care policymakers were very weak in this respect. Not only did policymakers fail to engage stakeholders opposed to the reform; they actively (although perhaps unintentionally) alienated stakeholders that could conceivably have served as allies. Stakeholders consistently cited displeasure over insufficient engagement with the government, portraying the engagements as mere briefings, rather than inviting dialogue.

Policymakers for VHI must leverage opportunities to strategically engage potential supporters, by finding areas of alignment between the goals of VHI and the concerns and interests of stakeholders. This should include both internal stakeholders – the bureaucratic roadblocks described earlier – as well as external actors. If administrators within the MOH are trying to stymie the progress of VHI, the technical units may have to resort to hierarchical processes by

engaging the Minister on the issue, who would be better placed to ‘unblock’ any resistance within his ranks.

Political commitment to the policy should be mobilized from within.

It is argued that ‘simply exhorting leaders to commit to national health insurance is insufficient to move countries to scale up coverage’ (Fox and Reich 2013). Malaysia’s unique dynamic, whereby the Prime Minister also serves as Minister of Finance, means that there are few formal checks on the PM’s policymaking power. The fact that PM Najib and his Cabinet approved 1Care at the initial concept stage yet retrenched this position in the lead-up to the 2013 elections, demonstrates the lack of political commitment to the reform.

The primary architects of 1Care – the National Health Financing unit – were technical bureaucrats and not politicians. The tension between technical and political dimensions of healthcare reform must be carefully balanced in to achieve success. Although the NHF were highly qualified from the technical perspective and cognizant of the political ramifications of their proposal, they were unable to manage and override internal political barriers to the reform, even as actors within the government. The lack of a strong champion for the reform at the highest political levels of the MOH was also a critical weakness.

With respect to political commitment, the VHI reform is on a much more solid footing than 1Care. Health Minister Subramaniam originated the idea for VHI and has made it a priority for his tenure, securing Cabinet approval and an initial budget to start the initiative. The small scale of VHI makes it considerably less of a political risk than 1Care, and with a highly placed and motivated politician helming the reform, the VHI should be secure in the short-term. However, as with any reform, there is a risk if there is a change in administration after the upcoming 14th general election. Thus, the technical teams should push for VHI implementation begin as soon as possible, with the enrollment of migrant workers.

4.5.2 Goals and strategies for VHI in the longer term

The goal of VHI is to serve as an instrument to organize out-of-pocket spending and pool risk across individuals, using channels such as strategic purchasing to pass on cost-savings to its policyholders. VHI will increase choice for consumers by introducing a new, lower-cost health insurance option to the market. As the VHI gains market share, increasing competition and putting pressure on the for-profit market, existing PHIs should respond by offering products with lower premiums or more generous benefits packages.

However, for policymakers to think strategically towards long-term national objectives for the healthcare system, building blocks should be put in place in the present day to ensure that vision is feasible. Furthermore, there is a risk of VHI promoting a two-tiered system if principles of equity and solidarity are not enforced early on in the scheme.

The current patterns of health financing in Malaysia demonstrate the critical importance of seeking diversified sources of funding. As the rate of growth in health expenditure outpaces economic growth, the health system will not be sustainable without a transformation in the longer-term. If the Ministry of Finance maintains its stance against significantly increasing public expenditure on health, the public sector risks the prospect of increased rationing and thinner coverage of lower quality services. Given this context, there are several strategies the MOH should consider as it implements VHI, to lay the groundwork for longer-term goals that will make VHI a vehicle for health system transformation.

Including the poor in VHI as a pillar for equity and solidarity.

As discussed, inclusion of the poor is a critical pillar to establish an equitable and inclusive health system, as espoused by Malaysia's national policy. Rather than attempt to convince the MOF to divert funds to cover a large swathe of the population (such as the B40, or bottom 40

percent, a population group frequently targeted for economic incentives), it is more important to establish a principle and political commitment towards the poor. It will be more politically feasible for the MOH to negotiate coverage of a smaller subset of the low-income population, such as the bottom five or ten percent. Ideally, to avoid the potential for a two-tiered system, this should occur simultaneously with the inclusion of politically strategic groups such as civil servants.

It may not be feasible to include low-income Malaysians into VHI in the short or even medium term but establishing the commitment to do so can be made within this timeline. MOH policymakers should be on the look-out for a window of opportunity to encourage government leaders to make a public commitment to subsidizing the poor under the VHI scheme. The statement would need to present a clear enough commitment that would be politically difficult to retract.

Establishing an adequate benefits package.

One of the key components of social health insurance is the establishment of a minimum benefit package that will be available to the entire population. Policymakers should strategize so that VHI will provide a natural avenue towards the creation of this package and prevent the emergence of a two-tiered system.

When low-income Malaysians and civil servants are eventually brought into the VHI scheme, they should be provided with the same benefit package, to avoid creating an entitlement to civil servants to a generous package that would not be sustainable to provide to the entire population under SHI. Again, this step is not likely to occur until the longer-term, but the MOH can take concrete actions in the short term to prepare for the development of a basic package, beginning with the analytical studies needed to develop the contents of the package. Based on this analysis, and the products offered under VHI, initial steps can be taken to determine which

services would be comprised in the basic package, and which services would be considered supplementary. These would serve as a guideline for the eventual basic and supplementary packages under SHI.

The VHI can also use its presence in the PHI market to signal the value of defining a common benefit package that would be offered across all insurers. This would ease the transition towards a universal package, and for-profit PHI could maintain coverage of supplementary or luxury services. The government can use its linkages with the Central Bank, which regulates the PHI market, and through groups such as the Joint Technical Committee, a collaborative group for insurers in Malaysia, to begin raising awareness on the benefits and needs of establishing a basic package.

Introducing new provider payment mechanisms.

One of the key areas where VHI can set the foundation for longer-term change is in implementing new provider payment mechanisms (PPMs). This can be done incrementally, allowing time for the VHI to build capacity, while also avoiding a similar outcry from private providers that was spurred by 1Care's proposals to use capitation and DRG payments.

In the short-term, VHI will take over the SPIKPA product, which covers inpatient admissions at government hospitals for migrant workers. This presents an opportunity to pilot test a shift in PPM. For example, moving from fee-for-service to DRG reimbursement at public hospitals. Implementing DRG payment systems would require building capacity for the VHI, government, and hospitals, including the adoption of a common system of coding and pricing, and producing costing data for DRGs. The MOH has been developing a case mix system or localized DRG system in a small number of hospitals, which can serve as a starting point for implementation. The introduction of new PPM would ideally be coupled with increased financial autonomy for public hospitals, which currently channel earnings back to a centralized

consolidated fund. Doing so would provide stronger incentives for hospitals to increase efficiency and would give require hospital managers to take on more responsibility over their budgetary allocations.

Through its various product offerings, VHI can test different methods of PPM and build its capacity towards creating a strategic purchasing function. This will serve as a critical step towards strengthening the health system for the longer term.

CHAPTER 5. CONCLUSION

When undertaking health system reform, applying strategies that address a country's political economy is a critical, yet often neglected step. Whereas reforms in health financing are often proposed in highly technical terms, what is technically optimal may not necessarily be politically feasible. Assessing the political economy of reform, using approaches such as stakeholder analysis and political mapping, enables the identification of barriers to reform, and facilitates the development of strategies to overcome these barriers. This process is necessary to create and implement politically feasible and sustainable policies.

This thesis seeks to demonstrate the importance of political factors in the adoption and implementation of comprehensive health systems reform, by examining two reform attempts in Malaysia. The 2009 1Care policy was a long-term vision to move from tax-funded universal coverage towards adopting a national social health insurance system. Yet the ruling coalition did not promote 1Care as a political priority, and the reform failed to make a significant impact on the public agenda. The release of a concept paper on 1Care led interest groups opposed to the reform to instigate a media campaign against the reform. As various stakeholder coalitions mounted efforts to block the reform, the government maintained a passive stance, and the reform was quietly shelved in the lead-up to elections.

I posit that 1Care was effectively doomed by a lack of political support by the Prime Minister and ruling coalition. Had the government fully exercised its political will to support 1Care, it is unlikely that the stakeholder opposition which arose in response to the policy would have been sufficient to block the reform. The reform also suffered without a policy entrepreneur that could strategically identify when to seize the timing to introduce reform and rally support within the political leadership. The fact that the PM, Economic Council, and Cabinet had

approved the 1Care concept in the initial stages suggests that there was a potential window for the reform to be pushed further, but policymakers were unable to strategize accordingly.

Due to an insufficient understanding of the institutional and political barriers to health care reform in Malaysia, policymakers were unsuccessful in passing the 1Care social health insurance reform. Currently, the Ministry of Health is undertaking the formation of a government-linked, non-profit Voluntary Health Insurance (VHI) scheme. Initially targeting a small subset of the population, the VHI scheme will serve as a vehicle to pool contributory financing and provide a benchmark for the largely unchecked private for-profit health insurance industry. VHI represents an incremental step considerably narrower in scope and magnitude than 1Care, but with the potential to lay a foundation for future larger-scale reform.

However, for VHI to create the groundwork for future, larger-scale reforms, policymakers must consider political strategies at an early stage to ensure this transformation occurs, and to avoid a repetition of the 1Care experience. Enforcing principles of equity and solidarity by including low-income populations in the scheme at an early stage is critical. Resisting the political pressures to cater to well-mobilized populations such as civil servants and going down the route of a two-tiered system is also of paramount importance.

One of the key policy messages evident from this research is that strong political commitment to reform is imperative to its success. A country's political institutions affect the political calculus for reform from its outset; politicians calculate the political feasibility of a reform given checks and balances that they will face (Fox and Reich 2013). Countries with significant institutional and partisan veto points often struggle to pass wholesale reforms (2013). Yet the Malaysian experience suggests that countries with minimal veto points still face difficulty passing transformative health system reform, as was the case with 1Care. Despite the locus of veto power residing with the Prime Minister and the top leadership, achieving social health

insurance was not deemed a high enough priority for the ruling coalition to expend its political capital. Thus, political strategies for reform should not only consider external stakeholders and vested interest groups, but also the internal political and bureaucratic dynamics at play.

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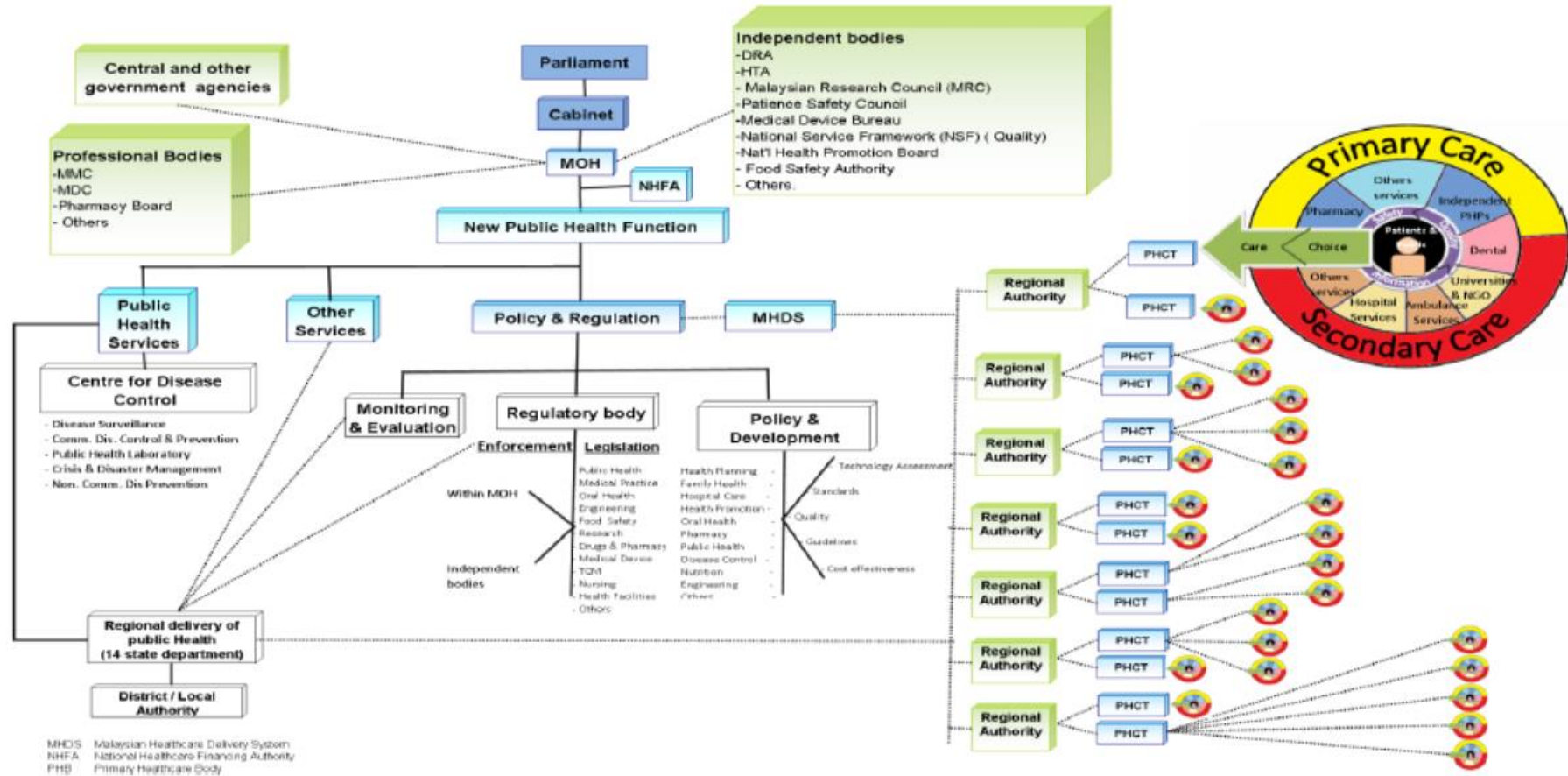
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Appendices

Annex 1. Key health financing indicators, 1997 – 2015, Malaysia National Health Accounts

Year	Total Health Expenditure, Constant (2010 USD Million)	Per Capita Spending, Constant (2010 USD)	THE as % GDP	General Govt Health Expenditure as % General Govt Expenditure	Public Health Expenditure as % THE	Private Health Expenditure as % THE	OOP as % of THE	OOP as % of Private Health Expenditure	Private Health Insurance as % THE
1997	4,952	227	2.94%	4.79%	52.2%	47.8%	35.45%	74%	3.56%
1998	3,543	158	3.16%	4.86%	52.7%	47.3%	34.57%	73%	4.07%
1999	4,010	175	3.27%	5.13%	53.3%	46.7%	34.25%	73%	4.28%
2000	4,562	194	3.28%	5.48%	53.8%	46.2%	34.88%	76%	4.41%
2001	5,144	213	3.68%	5.64%	56.8%	43.2%	31.63%	73%	4.62%
2002	5,443	220	3.69%	5.49%	56.1%	43.9%	32.17%	73%	5.08%
2003	6,675	264	4.29%	6.28%	58.3%	41.7%	30.76%	74%	5.37%
2004	6,752	261	4.04%	6.72%	55.4%	44.6%	34.25%	77%	5.55%
2005	6,560	248	3.56%	5.62%	50.1%	49.9%	38.83%	78%	5.60%
2006	7,893	294	3.93%	6.17%	53.7%	46.3%	36.44%	79%	5.31%
2007	8,894	327	3.89%	5.92%	52.9%	47.1%	36.66%	78%	5.46%
2008	9,263	336	3.74%	5.36%	53.8%	46.2%	36.12%	78%	5.93%
2009	10,047	360	4.32%	6.18%	56.7%	43.3%	32.87%	76%	6.46%
2010	11,959	418	4.25%	7.17%	55.5%	44.5%	34.05%	77%	6.52%
2011	12,947	446	4.16%	6.76%	53.0%	47.0%	36.36%	77%	6.92%
2012	13,920	472	4.29%	6.11%	53.6%	46.4%	35.70%	77%	6.66%
2013	14,421	477	4.33%	6.17%	52.7%	47.3%	37.55%	79%	6.62%
2014	15,208	496	4.45%	6.57%	53.1%	46.9%	37.41%	80%	6.51%
2015			4.55%	6.67%	51.5%	48.5%	37.73%	78%	7.70%

Annex 2. Functional relationships in the restructured health system proposed by 1Care



Source: 1Care Concept paper (MOH Malaysia 2009)

Annex 3. Selected clippings from the TakNak 1Care! Campaign, 2012

ADMISSION is FREE
 ~ Specially organised for ALL rakyat ~
 Lend your support • Protect your welfare



Organised by the Perak Medical Practitioners' Society

Date: **18th March 2012** (Sunday)
 Venue: Chung Hwa Association
 Kampung Koh,
 Sitiawan, Perak.
 Time: **4:00 pm – 7:00 pm**

1Care Public Forum – Sitiawan

We would like to invite you, the RAKYAT, and your friends to join us and lend your support to protect the welfare of the RAKYAT affected by the proposed health care transformation (1Care) by the Federal Government. 10% of your total household income will be contributed towards the NATIONAL HEALTH FINANCING SCHEME (NHFS).

**Why PAY MORE
 And GET LESS for 1CARE?**

1.	Can you choose your OWN Doctor?
2.	Do you have to VISIT TWICE for treatment & medicines?
3.	Will all ILLNESSES and all TREATMENTS be covered by 1 care?
4.	Can you seek treatment throughout the 24 hrs?
5.	Do you get to see Doctor / get Medicines of your choice?
6.	Can you get consultation for TWO complaints with one APPOINTMENT?



Your Money or Your Life?

The BN government thinks that your health and life - or rather your sickness and desire to live - is a great market to tap into. This is because in the 10th Malaysia Plan, the government says that it should no longer treat healthcare as a social obligation but as a very profitable income generating sector.

But to us ordinary rakyat, things are more down to earth than the billion ringgit healthcare profits the government and big business are drooling after:

BEWARE 1CARE

Key features of proposed 1CARE Malaysia

- > **Compulsory contribution of up to 10% from all salaries, goes to NHFA (National Healthcare Financing Authority) fund which will pay doctors and hospitals for services**
- > **You pay before service, meaning 10% must be deducted from your pay, whether you healthy or ill**
- > **Patient limited to 6 visits per year, 1 medical case per visit**
- > **Fund will only cover basic illnesses and generic medicine**
- > **Patient must carry a 1CARE membership card
 No card = no record = no treatment.**