

The political economy of health financing reform in Malaysia

Kevin Croke^{1,*}, Mariana Binti Mohd Yusoff², Zalilah Abdullah³,
Ainul Nadziha Mohd Hanafiah³, Khairiah Mokhtaruddin⁴,
Emira Soleha Ramli⁴, Nor Filzaton Borhan⁵, Yadira Almodovar-Diaz¹,
Rifat Atun¹ and Amrit Kaur Virk¹

¹Department of Global Health and Population, Harvard T.H. Chan School of Public Health, 677 Huntington Ave, Boston, MA 02115, USA, ²Planning Division, Ministry of Health, Block E6, Parcel E, Federal Government Administration Centre, 62590, Putrajaya Malaysia, ³Institute for Health System Research, Ministry of Health, Blok B2, Kompleks Institut Kesihatan Negara (NIH) No.1, Jalan Setia Murni U13/52, Seksyen U13 Setia Alam, Shah Alam, Selangor 40170, Malaysia, ⁴Razak School of Government, Menara Prisma, Level 5, 26, Persiaran Perdana, Presint 3, Putrajaya 62675, Malaysia and ⁵Institute for Health Management, Ministry of Health Malaysia, Blok B1, Kompleks NIH, Jalan Setia Murni U13/52, Seksyen U13, Setia Alam 40170 Shah Alam, Malaysia

*Corresponding author. Department of Global Health and Population, Harvard T.H. Chan School of Public Health, 677 Huntington Ave, Boston, MA 02115, USA. E-mail kcroke@hsph.harvard.edu

Accepted on 20 August 2019

Abstract

There is growing evidence that political economy factors are central to whether or not proposed health financing reforms are adopted, but there is little consensus about which political and institutional factors determine the fate of reform proposals. One set of scholars see the relative strength of interest groups in favour of and opposed to reform as the determining factor. An alternative literature identifies aspects of a country's political institutions—specifically the number and strength of formal 'veto gates' in the political decision-making process—as a key predictor of reform's prospects. A third group of scholars highlight path dependence and 'policy feedback' effects, stressing that the sequence in which health policies are implemented determines the set of feasible reform paths, since successive policy regimes bring into existence patterns of public opinion and interest group mobilization which can lock in the status quo. We examine these theories in the context of Malaysia, a successful health system which has experienced several instances of proposed, but ultimately blocked, health financing reforms. We argue that policy feedback effects on public opinion were the most important factor inhibiting changes to Malaysia's health financing system. Interest group opposition was a closely related factor; this opposition was particularly powerful because political leaders perceived that it had strong public support. Institutional veto gates, by contrast, played a minimal role in preventing health financing reform in Malaysia. Malaysia's dramatic early success at achieving near-universal access to public sector healthcare at low cost created public opinion resistant to any change which could threaten the status quo. We conclude by analysing the implications of these dynamics for future attempts at health financing reform in Malaysia.

Keywords: Health reform, Malaysia, political economy, stakeholder analysis, historical institutionalism

Introduction

Why has comprehensive health financing reform failed to be adopted in Malaysia, despite its frequent presence on the health policy agenda, and despite support from the country's political

leadership since the mid-1980s? On a number of occasions over the past 30 years, Malaysian policymakers have attempted to transform their existing hybrid system, in which tax-funded, publicly provided care coexists with largely out-of-pocket financed private care, into a

Key Messages

- This study examined efforts at health financing reform in Malaysia over 35 years, seeking to identify why health financing reforms were continuously proposed by the government but consistently blocked by opponents.
- Data were gathered through more than 40 interviews with health sector stakeholders in Malaysia, as well as other informants knowledgeable about policy and political dynamics.
- We examined the relative explanatory power of theories of interest group competition, veto points and historical institutionalism/path dependency.
- We found that the historical institutionalist approach best explains Malaysia's persistently blocked reforms, while interest groups mobilization played an important secondary role. There was a clear path dependency to the process: previous expansions of subsidized health services had created public opinion very resistant to financing changes.
- Stakeholders argue that Malaysian policymakers observed public backlash to reform proposals, feared political consequences and thus refrained from implementing their preferred reforms.

unified insurance-based system. On each occasion, the proposal was defeated, despite the fact that a number of powerful groups and actors in Malaysian politics favoured health financing reform, and the Malaysian political system has virtually no formal institutional barriers (veto gates) to policies advocated by the ruling coalition (Tsebelis, 2002).

Some analysts understand health system reform as a contest among interest groups, in which reform will proceed if it gains the support of cohesive and mobilized politically powerful groups. This cannot explain the Malaysian case, since healthcare reform had support from the most powerful institution in Malaysian politics at the time, namely the then-ruling United Malays National Organization (UMNO) party, and its successive Prime Ministers (PMs). It also had support from other economically important groups such as private sector health providers and various large government-linked corporations (GLCs). It was opposed by weaker groups including NGOs, academics, opposition parties and doctors' professional associations. While interest group opposition to blocked financing reform has been part of the story in Malaysia, it does not appear to have been decisive. Other influential work on the political economy of health reform identifies the number of veto gates in the policy process as a fundamental determinant of the success or failure of health reform (Immergut, 1992; Steinmo and Watts, 1995; Sparkes *et al.*, 2015). In contrast, we show that this cannot explain the failure of comprehensive healthcare reforms in Malaysia since there are essentially no formal veto gates in its political system that restrain elected majorities from passing their preferred legislation.

Stakeholder interviews for this project highlighted a different factor: political leaders' perception of public opinion was a major barrier to reform, specifically because of the *sequence* in which health coverage had been rolled out (Fox and Reich, 2015). Interviewees stressed that while interest group opposition was an important factor, the fundamental constraint on reform was public support for the existing system of health finance. Interviewees argued that because the Malaysian public already enjoyed near-universal access to publicly provided healthcare at modest cost, Malaysians viewed reform attempts primarily as a threat. This feeling was perceived to be broadly shared among the population but was perhaps most salient for the group at the heart of the then-ruling party's electoral coalition, the rural ethnic Malay population. Thus while the government had long wanted to transform the health finance system, and had the electoral majorities necessary to do so, it stepped back from doing so each time in the face of citizen group mobilization and hostile public opinion. This is what Pierson (1993) describes as a 'policy feedback' effect, since this public opinion was perceived to result from Malaysia's

earlier health policy achievements, most notably the provision of healthcare access to the public at very low out-of-pocket cost, including to the rural poor. While health policymakers worried about the sustainability of this system, they did not manage to convince the public at large that reforms would preserve low cost, progressively financed access to healthcare, and political leaders were therefore unwilling to move forward with reforms. The situation in Malaysia shows strong resemblance to the politics of welfare state retrenchment in the USA and Europe, which Pierson (1996) argues is characterized by strong public support for and interest group mobilization behind the healthcare status quo, loss aversion as the public contemplates reform, and general inertia in political institutions.

The reasons why Malaysia did not adopt health financing reforms which would transition the country toward a social health insurance (SHI) system are of broader interest, since there has been global momentum in developing countries away from government financing and provision and towards SHI systems (Wagstaff, 2010). Malaysia's resistance to these reform proposals can shed light on the political economy dynamics of similar reforms in other settings.

Methods

In order to understand the views of health system participants on the politics of Malaysia's health reform efforts, we conducted an in-depth stakeholder analysis using semi-structured interviews with >40 stakeholders with interest in or influence over health system reform (Reich, 1996). We defined stakeholders as 'actors who have an interest in the issue under consideration, who are affected by the issue, or who—because of their position—have or could have an active or passive influence on the decision making and implementation processes' (Brugha and Varvasovszky, 2000). We developed a preliminary list of potential stakeholders, and refined it in consultation with counterparts in the Ministry of Health (MOH) and academia. These stakeholders included current and former officials at key government ministries as well as healthcare providers (public and private sector physicians and hospital managers), educational and accreditation bodies, NGOs, international organizations, business leaders and researchers. We then analysed the interview transcripts and other primary source documents to identify each stakeholder's relative power, position on both past and proposed future health reforms, the intensity of their commitment and their degree of mobilization around health reform (Roberts *et al.*, 2008).

Second, in addition to this primary data collection via interviews, we analysed the secondary literature on Malaysia's health reform efforts. Third, we analysed the comparative politics literature on the

Malaysian state and Malaysia's political economy. Finally, we assessed the extent to which the mechanisms and processes identified by interviewees and in the secondary literature were consistent with theories of interest group competition, veto gates or path dependency, and the relative contribution of each of these theories.

Theoretical framework

There is no single generally accepted theory which is universally used to explain variation in health system reform outcomes, but rather a set of theories, which span several academic disciplines (Roberts *et al.*, 2008). Accordingly, this analysis examines the extent to which several of the most prominent of these theoretical frameworks can explain the success or failure of health financing reform in Malaysia: interest group theory, veto gates theory and historical institutionalist theory, with a focus on mechanisms of path dependency.

Interest group-centred theory focuses on the ability of powerful groups (such as business interests, economic elites or medical providers) to block health reforms which go against their interests. Healthcare reforms create winners and losers, which can result in intense mobilization and lobbying for or against reform proposals by groups in society (Kauffman and Nelson, 2004). According to theories of interest group competition, policymaking is a contest among various interested parties, with reforms most likely to progress if the coalition of groups mobilized in favour of change is stronger and more unified than the coalition blocking reform, and vice-versa. Roberts *et al.* (2008, pp. 70–71) highlight the importance of analysing the relative power, position and level of mobilization of interest groups outside of government, as well as ministries and actors inside the government.

A second set of theories on the determinants of healthcare reform relate to the institutional features of a country's political system, namely the number of veto gates (Immergut, 1992; Tsebelis, 2002). Any person or group with the power to block policy change can be understood as a veto gate, which means that in political systems with many veto gates, many actors have a legal ability to block or seriously impede major reforms proposed by the executive, including minority parties in the legislature, courts and state governments. (For example, the proliferation of veto gates in US political institutions is often used to explain the repeated failure of legislation to ensure universal health coverage; see Steinmo and Watts, 1995.) In systems with fewer veto gates (such as Great Britain), parliamentary majorities face few institutional impediments to passing legislation.

Finally, we draw on the historical institutionalist tradition in political science, particularly the concepts of path dependency and policy feedback. Path dependency in this context refers to the idea that the set of feasible policy options at any point in time is shaped by the policy choices of the past, including the institutional arrangements and configurations of public opinion generated by these past choices (Pierson, 1996). As in interest group theory, the relative power of institutions and interest groups matters, but historical institutionalist theories stress that interest groups do not emerge organically from society. Rather, the ways in which various groups are mobilized to promote or defend certain policy options, and the views of the public about these options, are often a function of the policies that have been previously enacted. Pierson (1993) describes as 'policy feedback' the idea that policies create public opinion, which then constrains future policies. Successful policies mobilize interest groups and shape public opinion in their own defense, and can imbue systems with a

degree of stability that might not be predicted simply by assessing the relative power of groups more broadly, or the legal hurdles to reform.

Major health system reform initiatives in Malaysia

The central thrust of health policy in Malaysia from independence in 1957 through the early 1980s was the expansion of essential health services to the entire population, particularly the rural poor. Malaysia was very successful at this task, achieving broad access to primary healthcare, and rapid reductions of under-5 and maternal mortality (Pathmanathan *et al.*, 2003), at relatively modest cost, and while providing substantial financial protection, especially for the poor (Rannan-Eliya *et al.*, 2016). Initial impetus towards health financing reform in Malaysia came about in 1983, when PM Mahathir Mohamad announced a new economic direction for Malaysia based on a renewed focus on private sector growth. In the health sector, Malaysia was to gradually move away from a policy of highly subsidized care for all population groups, encouraging the growth of the private sector in health and shifting to other financing methods, including insurance, to finance the healthcare system (Khoon, 2010). In 1985, the government commissioned the first of a number of studies proposing the transition to an insurance-based system. In line with this vision, and encouraged by senior Malaysian policymakers, the private health sector grew rapidly—the number of private hospitals quadrupled from 1980 to 2000, from 50 to 224 (Chee and Barraclough, 2007), and the private, out-of-pocket share of national health expenditure grew steadily. In the 1990s, there were a series of incremental reforms in this direction, such as the corporatization of Hospital Kuala Lumpur's cardiac unit into the National Heart Institute in 1992, followed by contracting out Malaysia's drug distribution system to private companies in 1994, and in 1996, outsourcing of hospital support services to private suppliers. Despite these incremental changes, the Mahathir-led government refrained from enforcing fundamental systemic restructuring of the health financing system. Nevertheless, this vision of reform continued to be proposed in a series of government-commissioned analyses of the health system throughout the 1980s and 1990s (Juni, 2014).

As a result, comprehensive financing reform remained on the agenda. In 1999, the government's declaration of its intent to corporatize public hospitals, to enable them to function along commercial lines, was a key tipping point in the politics of reform. A vocal and well-organized opposition to this reform emerged: the Citizen's Health Initiative coalition, organized by non-governmental actors and activists and academics from the Malaysia Medical Association, University Sains Malaysia and the Consumer Association of Penang (Leng and Hong, 2015). With elections approaching, the government backed off of its corporatization proposal, and even increased funding for public hospitals (Kuhonta, 2011).

After this setback, comprehensive healthcare reforms stayed off the Barisan National-led government's agenda until the late 2000s, when the MOH began to develop the '1Care' plan. This plan outlined major transformation in the healthcare financing system, again stressing the introduction of an insurance-based model. '1Care' ended up being 'arguably ... the most contentious issue in health in Malaysian society spanning three decades' (Leng and Hong, 2015). The substance and rationale for the reform appears to have shifted from a focus on the need to limit public spending on health (Barraclough, 2000), which was central to PM Mahathir's justification for earlier reform proposals, to a desire to pool public and private health spending and thus improve the efficiency of health spending. Yet the 1Care proposals still broadly reflected a shift to an insurance-based system, and inspired opposition from a coalition

similar to the one that opposed the earlier corporatization effort. An early draft of the plan was leaked to the media by opponents, and a social media campaign against the plan ensued. Between February and June 2012, the 'TakNak 1Care' ('Do not want 1Care') movement emerged, with a highly visible online presence to mobilize opposition to the plan. Again eager to avoid vocal opposition before the impending 2013 national elections, the government once again shelved its plans to transform the health financing system.

Thus, the basic pattern of healthcare reforms in Malaysia from the early 1980s until the present day is that Malaysia's powerful political leadership favoured dramatic healthcare financing and delivery reforms, yet each attempt was comprehensively blocked by civil society mobilization—which the government believe had strong roots in public opinion—and systematic reforms were never fully implemented. In the following sections, we consider competing explanations for this.

Results: stakeholder analysis

We conducted a stakeholder analysis analysing the positions, interests, power and influence of relevant actors within the Malaysian system and their positions on health system reform. Our sample included representatives from the Malaysian government, quasi-governmental corporations, professional and accreditation associations, political parties, civil society (NGOs, academia, think-tanks), as well as public and private healthcare providers in Malaysia. We analyse their positions on key past reform attempts, the reason for these positions and the degree to which their opposition was perceived as decisive in preventing the implementation of these reforms.

Supporters of reform

Our interviews highlighted three groups that supported health system reform in Malaysia during key episodes of attempted reform from the mid-1980s to the current day: senior policymakers in UMNO and technocrats in key policy planning agencies such as the Economic Planning Unit (EPU), senior leaders in the MOH, and large private sector and quasi-government corporate entities either active in the health sector or interested in investing in the sector. High-level political support in the early 1980s originated with the political leadership of the ruling Barisan Nasional coalition, led by the UMNO party, principally the PM's Office, and the technocrats in the EPU. The motivation of these state actors came from various sources. PM Mahathir was motivated by an ideological and policy vision for a reduced state role in healthcare financing and delivery, a larger private role and an eventual transition to a partially privatized, insurance-based system. Other political actors may have been more focused on SHI benefits for specific constituencies, such as Malaysia's large and politically important civil service. In the MOH, interviewees noted persistent internal divisions about the precise form of reform, with some stakeholders believing that problems could be solved with increases in the budget, rather than comprehensive reform. Other stakeholders noted that while the policy side of the ministry was in favour of financing reform, the administrative side (which would be heavily involved in implementing new payment models) was much less enthusiastic. Nonetheless, the MOH has always been at least formally in favour of government reform, and was clearly a central driver of the 1Care reform proposal. Finally, private and corporate interests including private hospitals and GLCs generally supported reforms since it promised them a larger share of the public sector dominated healthcare market. (GLCs are for-profit companies directly or indirectly under Malaysian government control, and are large

stakeholders in commercial private healthcare, owning 40% of private hospital beds in Malaysia.)

Opponents of reform

The main groups against reform were civil society actors (consumer groups and trade unions), medical provider associations and opposition parties. While UMNO dominated Malaysian politics throughout the period in question and opposition parties had never held power, these opposition parties played important roles in health reform debates. They all opposed the reforms of the late 1990s such as the proposal to corporatize all public hospitals in Malaysia; when the main opposition parties united to form the 'Barisan Alternatif' coalition before the 1999 General Election, their manifesto committing to 'abolish all programs to privatize the public health system' (Barisan Alternatif, 1999). They have remained opposed to the government's proposals for health system reform: during the 2013 General Election, the main opposition parties released a common manifesto once again declaring that they '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' (Opposition Joint Platform, 2013).

Civil society groups, such as NGOs, trade unions and consumer groups, have similarly opposed the government's health system reform proposals. The important role played by this sector is in itself an anomaly, given that civil society has been relatively weak in Malaysia compared to other countries at its level of development, due to a legacy of state policies which constrained the space for independent civil society organizations (Pepinsky, 2009). Unions, consumer groups and health provider groups rallied together to form the Citizen's Health Initiative in 1997, and a similar set of groups formed the Coalition Against the Privatization of Health Services (CAPHS) in 2005.

A third group of reform opponents were private sector doctors, who comprise approximately half of all doctors in Malaysia. The key national bodies representing doctors and hospitals in the private sector include the Malaysian Medical Association (MMA), with ~8000 members of the total 49 000 doctors in the country, the Federation of Private Medical Practitioners Associations, Malaysia (FPMAM) with 5000 members, and the Association of Private Hospitals Malaysia (APHM). Among clinicians, the largest and most influential in health financing reform debates are the estimated 7000 private general practitioners (GPs) in Malaysia, who function as either group practices or as solo independent clinics.

While civil society and NGOs were more prominent in privatization debates in the 1990s (Barraclough, 1999), opposition from private GPs was critical in thwarting the implementation of the 1Care reform. Stakeholders identified specialist clinics in particular as vehement opponents of 1Care, since they would likely lose patients and revenues under a system that incorporated a family medicine 'gatekeeper' who would only refer to patients to them who could not be treated by a GP (Interview no. 9, 2015; Leng and Hong, 2015). Conversely, interviewees argued that non-specialist GPs who had fewer patients (and lower revenues) would be potentially open to a capitation-based system that would increase their patient numbers, with their support or opposition depending critically on the capitation rates to be agreed with the government (Interview no. 3, 2015).

Interest group opposition in itself is a common feature of health reform. But its success in Malaysia is notable, given that, first, in other sectors, the Malaysian state is distinctive for its ability to carry

out difficult policies in the face of organized opposition from social groups. Slater (2010) e.g. notes that the Malaysia has ‘one of the strongest...state apparatuses in the developing world’ from an early stage ‘noteworthy for the effectiveness of its coercive and administrative institutions’ and highlights that, in contrast to so many developing countries, it has had relatively little trouble extracting taxation from economic elites. Second, in many health reform episodes, health providers are the central interest group. At several instances in the health reform debates in Malaysia, providers were partially divided about reforms. The fact that the government clearly chose to step back from conflict on a number of occasions despite its strength vis-a-vis civil society, and despite divisions in the opposition, suggests something significant about the underlying politics of health reform, which we discuss further below.

Veto gates analysis

We now turn to ‘veto gates’ theory for an alternative explanation for the failure of healthcare reform in Malaysia. Veto gates theory contends that the number of decision-making points or ‘veto gates’ through which a policy must pass are potential hurdles that can waylay or block the passage of government policies and programs (Tsebelis, 2002). A classic example is the USA, where despite opinion polls showing majorities of the public supporting expansion of health coverage, legislation towards this goal was blocked over more than 50 years because of the large number of ‘veto points’ in the American system: two houses of Congress (one of which has rules which require a supermajority to pass most legislation), a judiciary with the power to strike down legislation, and a federal system with a pivotal role for states in decision-making and policy implementation. Closer to Malaysia, Selway (2011) argues that the fragmenting effect of the Thai electoral rules prior to the 1997 constitutional reform prevented health reform in Thailand.

However, this theory is problematic in Malaysia’s case, since it has unusually few veto gates. In Malaysia’s Westminster-style parliamentary system, a large degree of power is delegated to the PM by the majority party or coalition. As long as the PM retains the support of his party, there are few formal checks on his policymaking power. Internally, the PM’s position over the period in question was further strengthened by the ruling party’s centralization and strong internal discipline (Brownlee, 2007; Levitsky and Way, 2010; Slater, 2010). MacIntyre (2001) notes that during this period, ‘With the cabinet overwhelmingly dominated by UMNO, for most purposes the effective locus of veto power is within the UMNO leadership. If UMNO leaders favour a policy change, it easily obtains cabinet approval and passes quickly into law since there are no other veto players to be reckoned with.’ If the PM and the Cabinet decide to make a policy change (such as health reform), they have an automatic parliamentary majority. Therefore, ‘veto gates’ theory does not explain the government’s persistent failure to pass healthcare reform.

Historical institutionalist analysis

The final set of theories that we bring to bear on understanding the failure of healthcare reforms in Malaysia are historical institutionalist approaches. Historical institutionalist scholars view existing institutions—political and legal structures, formal and informal rules, laws and regulations—as the results of a series of political struggles between groups, emphasizing the contingent and historically determined nature of the process by which some social groups are mobilized into such issue conflicts while others remain latent or demobilized. Historical institutionalists also emphasize that political

institutions are ‘sticky’ and difficult to change, so that the initial form of institutions strongly influences policy choices long into the future (Pierson, 2004). Applied to health policy, historical institutionalist approaches emphasize (1) the importance of initial conditions when key institutions were created, which shape the initial form that institutions take; (2) the sequencing of health reforms; and (3) the alignment of large social and political groupings around policy issues, which is in turn shaped by the initial conditions and the sequencing of reforms (Hacker, 1998).

In Malaysia’s case, the issue of reform sequencing emerged as a critical explanation for the persistent failure of reform efforts. A number of stakeholders noted that the reason why the government feared pushing through these reforms was that they believed that the Malaysian public was deeply accustomed to low-cost services paid for out of general taxation, and would resist heavily any new system that required premiums and higher co-pays. Specifically, the point repeatedly raised was that it would be hard to make these changes, given how accustomed Malaysians were to current system.

Several interviewees noted the highly salient fact that patients pay just 5 ringgit (~\$1) for doctor’s visits as a symbolic element of the existing healthcare system that voters were extremely attached to:

Since independence, people have been given free care, subsidized to a level of \$1. Now, I am just trying to say: Can we top it up to \$5?... There is hue and cry from the public, and politicians who are following say no, why should we tax the public? So they know they are going to lose, politically the government will go down, because the opposition will attack. It is not going to happen. Interview no. 27 (2015)

One Ministry official stressed the same idea, noting that even mild increases in user fees at various points were seen as untenable for political reasons.

There a lot of people who are misusing emergency department... The emergency department is free. We say, we charge them 5 Ringgit. They say cannot! Politically unacceptable! Now you’re talking about, 2 Ringgit or 5 Ringgit is politically unacceptable, and now you’re going to talk about...health care financing, and transforming the healthcare system? How can it be acceptable? So I feel that sometimes... people who are making policies are not realistic. They want something, and yet they so scared of a small thing. Interview no. 1 (2015)

Another noted:

They [the public] will be very, very upset. In this country, anything other than free service will be upsetting. Because they are so used to not paying for health care. Even vitamins, supplements they want government to pay for them. So, somewhere along the line, you need a bold government... 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 health care financing, it may be political suicide... They do not know how to tell the rakyat [public]: Please pay for healthcare.

This public opinion dynamic is also related to the politics of the ruling party, in a way that points back to the circumstances at the creation of the modern Malaysian healthcare system shortly after independence. UMNO first emerged politically to defend the position of the ethnic Malay community in the years immediately prior to independence, and throughout its history, UMNO has delivered a wide range of benefits to the ethnic Malay community in exchange for their political support (Pepinsky, 2009; Slater, 2010). Health is an important component of this relationship (Barracough, 2000; Chee, 2008), and this political imperative to deliver services to the

rural Malay population can help explain the political logic of Malaysia's historic achievements in achieving broad access to healthcare. Given this political dynamic, UMNO leaders were unwilling to take steps that made it seem to their voters as if they were reducing their access to highly subsidized health services. They felt that, given the reliance of the ruling coalition on the votes of rural Malays who are the largest beneficiaries of the existing system, any change would be, in an interviewee's words, 'political suicide'.

This has been noted in the secondary literature—reflecting on the failure of the corporatization reform in 2000, Barraclough noted 'Any radical change to the role of the state as provider of public healthcare poses problems of political legitimacy for a ruling coalition which has historically projected itself as delivering socio-economic benefits to the population and especially to its principal constituency, the rural Malays' (Barraclough, 2000).

It was also noted in stakeholder interviews:

Who are the main users of the public healthcare service? Public servants, mostly from the Malays, and those who are ... from the rural area, who are also mostly Malay: they use this system. And they are being made to understand by the political rulers, that, in a way, we are giving it to you... So these are the group which will oppose very much, if the social health insurance people come in. It will be political suicide for the government if it comes in, because how are they going to talk to this group of people who had been receiving healthcare, especially in rural area throughout all these years, at the most negligible fees? Interview no. 3 (2015)

Others highlighted the extent to which the current Barisan Nasional coalition relies on smaller rural-based parties (such as from Sabah and Sarawak) and the votes of rural UMNO voters (in part because of gerrymandered parliamentary constituencies) who are perceived as more like to favour the status quo and therefore resist any changes to current benefits:

I don't think, under the current circumstances, where the political domination isn't as strong as it was before, it's that easy to reach that consensus. Especially [now], when you see the coalition where the party that represents more rural areas is getting stronger. So you can see the demand of the rural [population] where everything is being provided by the government is the key words. I don't think you want to touch reform... Good luck to the politician [who tries that].

These public opinion dynamics, working in conjunction with interest group opposition, were in our analysis the fundamental constraint to the implementation of health financing reform.

Discussion and conclusion

In this article, we examine the case of a health financing reform that never happened, in Malaysia. In doing so, we find that the theories of historical institutionalism, and its emphasis on path dependency through the mechanism of policy feedback, best explain the failure to implement comprehensive healthcare financing and delivery reform. In this section, we consider the Malaysian case in comparative perspective, and then consider the implications of this finding for future reform efforts.

International comparisons

A natural point of comparison for Malaysia's health reform is other recent reforms in middle-income countries. A common pattern is discernible in many such countries: typically the poor were relatively disadvantaged by an inequitable, two-tiered system, in which public expenditure favoured the relatively better off. For example in many

Latin American cases, spending per capita was much higher in parallel social security systems which served civil servants and the formal sector labour force, while the rural poor and informal sector workers relied on the underfunded public sector (Kauffman and Nelson, 2004). In these contexts, comprehensive reform towards a more universal and equitable insurance-based system was very difficult to pass, because of interest group opposition, but it was often politically popular (Harris, 2015). A key challenge in such cases was not winning over public opinion, but defeating interest group coalitions representing the relative elite groups (civil servants, urban middle class, some groups of medical providers) that benefited from the existing system. In a number of cases, democratizing reforms were key turning point which broke the political stalemate and triggered major health system reforms (Wong, 2004; Selway, 2011; Gomez-Dantes *et al.*, 2015).

However, applying this model of health reform to Malaysia is misleading because the starting point in Malaysia was roughly the opposite of this. Existing health spending was unusually progressive, in contrast to the fragmented and regressive systems common to other pre-reform health systems. The challenge was not defeating interest groups opposed to reform, but rather to reassure the public that a new system will maintain the universality and progressivity of the existing Malaysian system. In this regard, a more relevant comparator for Malaysia may be the group of health systems, like Hong Kong and Sri Lanka, which achieved early universal access to government-financed and -provided healthcare in parallel with out-of-pocket financed private sectors that accommodate wealthier consumers (Rannan-Eliya *et al.*, 2016). The experience of Hong Kong in particular provides close parallels: like Malaysia, Hong Kong has had a long history of attempted comprehensive health finance reform to shift to a unified national insurance-based system (Gauld, 2007), supported by successive governments, which were similarly unconstrained by formal institutions checks (or veto gates) on decision making. But comprehensive financing reform in Hong Kong was blocked by a number of factors, including wariness from the public, who were attached to the existing health financing system (Luk, 2014).

Implications for future reform efforts

The political dynamics of all reform efforts in Malaysia must be reassessed following the historic defeat in 2018 of the *Barisan Nasional* coalition and the election of former PM Mahathir Mohamed as leader of the opposition *Pakatan Harapan* coalition. However, an implication of our findings which apply to any future reform efforts is that an important obstacle will continue to be public opinion. Given the Malaysian system's remarkable achievements in access and financial protection, the public's uncertainty in the face of dramatic change can be seen as rational. Reform proposals will be more popular, and therefore more feasible, if policymakers can identify policy options which are clearly understood by the public as preserving these attributes. It is not enough to simply craft good policy; it must also be understood by the public as such.

However, creating a popular reform highlights important trade-offs. As Rannan-Eliya *et al.* (2013) have shown, the current health financing system in Malaysia is extremely progressive, since the highest income groups pay a large portion of taxes, but often opt for private sector healthcare options for themselves. Given this baseline, citizens do not seem irrational to worry that, depending on the details, reforms could shift the situation in a more regressive direction. It is also possible to design a comprehensive reform that shifts Malaysia to an insurance-based system which would give all

Malaysians access to public and private facilities, while maintaining or increasing progressivity, by making insurance premiums progressive and exempting the poor. But as Rannan-Eliya *et al.* (2013) note, this would likely involve higher levels of public spending. This may be an unwelcome trade-off to policymakers who had originally seen moving to an insurance-based system as a way to reduce growth in public expenditures on health. But the politics of reform may make it inevitable.

Finally, our interviews highlighted serious concerns regarding the process by which previous reform policies have been designed, specifically the extent to which the reform process was open and inclusive, and the extent to which broad groups of stakeholders were consulted and taken into account (Juni, 2014; Interview no. 7, 2015; Interview no. 16, 2015; Interview no. 38, 2015). A number of interviewees referred to the secretive process by which previous reforms had been developed as a key obstacle to generating broader buy-in, especially from key stakeholders such as medical professionals. Such a process would help not just with interest groups but also with public opinion. Political scientists have shown that in other settings, the public cannot easily make judgments about the content of complicated policy issues about which even specialists disagree. Rather, voters rely on cues from trusted stakeholders in the system about whether a given policy (such as a health reform proposal) is likely to be in their interests or not (Achen and Bartels, 2016). Crafting an inclusive process that generated input and buy in from previous reform opponents such as NGOs and medical professionals would be difficult, but could signal a broad social consensus on the need for reform, and would thereby reduce the likelihood of the public disapproval which was fatal to previous reform efforts.

Ethical approval: Ethical clearance was received from the Harvard School of Health Institutional Review Board and Malaysia's Medical Research and Ethics Committee (MREC) and all interviewees provided informed consent before participating in interviews.

Acknowledgements

This research was conducted as one component of the Malaysia Health Systems Research (MHSR) project, led by Harvard T.H. Chan School of Public Health Professors Rifat Atun, Peter Berman and William Hsiao. Comments and feedback on this research from Government of Malaysia counterparts and the broader MHSR team are gratefully acknowledged. This research was funded by the Government of Malaysia, via the Harvard T.H. Chan School of Public Health's Malaysia Health System research project.

Conflict of interest statement. None declared.

References

Achen CH, Bartels LM. (2016). *Democracy for Realists: Why Elections Do Not Produce Responsive Government*. Princeton, NJ: Princeton University Press.

Barisan Alternatif, 1999. *Barisan Alternatif Platform*. <https://dapmalaysia.org/en/about-us/our-history/barisan-alternatif-common-manifesto-1999/>, accessed 2017-04-06.

Barracough S. 2000. The politics of privatization in the Malaysian health care system. *Contemporary Southeast Asia* 22: 340.

Barracough S. 1999. Constraints on the retreat from a welfare-orientated approach to public health care in Malaysia. *Health Policy* 47: 53–67.

Brownlee J. (2007) *Authoritarianism in an Age of Democratization*. New York: Cambridge University Press.

Brugha R, Varvasovszky Z. 2000. Stakeholder analysis: a review. *Health Policy and Planning* 15: 239.

Chee HL. 2008. Ownership, control, and contention: challenges for the future of healthcare in Malaysia. *Social Science & Medicine* 66: 2145–56.

Chee HL, Barraclough S. (2007). The growth of corporate healthcare in Malaysia. In: Leng Chee H., Barraclough S. (eds). *Health Care in Malaysia: The Dynamics of Provision, Financing and Access*. New York: Routledge.

Fox AM, Reich MR. 2015. The politics of universal health coverage in low and middle income countries: a framework for evaluation and action. *Journal of Health Politics, Policy and Law* 40: 1023–60.

Gauld R. 2007. Which way forward? An analysis of Hong Kong's health system reform options. *Asia Pacific Journal of Public Administration* 29: 173–90.

Gomez-Dantes O, Reich MR, Garrido-Latorre F. 2015. Political economy of pursuing the expansion of social protection in health in Mexico. *Health Systems & Reform* 1: 207–16.

Hacker JS. 1998. The historical logic of national health insurance: structure and sequence in the development of British, Canadian, and US medical policy. *Studies in American Political Development* 12: 57–130.

Juni MN. 2014. Three decades of health financing study: did Malaysia learn anything? *International Journal of Public Health and Clinical Sciences* 1.

Harris J. 2015. "Developmental capture" of the state: explaining Thailand's universal coverage policy. *Journal of Health Politics, Policy Law* 40: 165–93.

Immergut EM. (1992). *Health Politics: Interests and Institutions in Western Europe*. Cambridge University Press, New York.

Interview no. 1. (June 2015). Interview with research team. Kuala Lumpur, Malaysia.

Interview no. 3. (June 2015). Interview with research team. Kuala Lumpur, Malaysia.

Interview no. 7. (June 2015). Interview with research team. Putrajaya, Malaysia.

Interview no. 9. (June 2015). Interview with research team. Kuala Lumpur, Malaysia.

Interview no. 16. (July 2015). Interview with research team. Putrajaya, Malaysia.

Interview no. 27. (July 2015). Interview with research team. Putrajaya, Malaysia.

Interview no. 38. (August 2015). Interview with research team. Putrajaya, Malaysia.

Kauffman RR, Nelson JM. (2004). *Crucial Needs, Weak Incentives: Social Sector Reform, Democracy, and Globalization in Latin America*. Washington, DC: Woodrow Wilson International Center for Scholars.

Khoo CC. 2010. Re-inventing the welfarist state? The Malaysian health system in transition. *Journal of Contemporary Asia* 40: 444–65.

Kuhonta E. (2011). *The Institutional Imperative: The Politics of Equitable Development in Southeast Asia*. Redwood City, CA: Stanford University Press.

Leng CH, Hong PH. (2015). '1 care' and the politics of healthcare in Malaysia. In: Weiss ML (ed). *Routledge Handbook of Contemporary Malaysia*. New York: Routledge.

Levitsky S, Way LA. (2010). *Competitive Authoritarianism: Hybrid Regimes after the Cold War*. New York, Cambridge University Press.

Luk SCY. (2014). *Health Insurance Reforms in Asia*. Oxfordshire, UK: Routledge, Milton Park, Abingdon.

MacIntyre A. 2001. Institutions and investors: the politics of the economic crisis in Southeast Asia. *International Organization* 55: 81–122.

Opposition Joint Platform 2013. https://www.slideshare.net/anwaribrahim_my/pakatan-rakyat-manifesto-bookenglish/, accessed 2017-04-06.

Pathmanathan I, Liljestrand J, Martins JM *et al.* (2003). *Investing in Maternal Health: Learning from Malaysia and Sri Lanka*. Washington DC: World Bank.

Pepinsky TB. (2009). *Economic Crises and the Breakdown of Authoritarian Regimes: Indonesia and Malaysia in Comparative Perspective*. New York: Cambridge University Press.

Pierson P. (2004). *Politics in Time: History, Institutions, and Social Analysis*. Princeton, NJ: Princeton University Press.

Pierson P. 1996. The new politics of the welfare state. *World Politics* 48: 143–79.

Pierson P. 1993. When effect becomes cause: policy feedback and political change. *World Politics* 45: 595–628.

Rannan-Eliya RP, Anuranga C, Manual A *et al.* 2016. Improving health care coverage, equity, and financial protection through a hybrid system: Malaysia's experience. *Health Affairs (Project Hope)* 35: 838–46.

- Rannan-Eliya RP, Anuranga C, Manual A *et al.*; IHSR Core Team (2013). *Malaysia Health Care Demand Analysis: Inequalities in Healthcare Demand Simulation of Trends and Impact of Potential Changes in Healthcare Spending*. Colombo: Institute for Health Policy.
- Reich MR. 1996. Applied political analysis for health policy reform. *Current Issues in Public Health* 2: 186–91.
- Roberts MJ, Hsiao W, Berman P, Reich MR. (2008). *Getting Health Reform Right: A Guide to Improving Performance and Equity*. New York: Oxford University Press.
- Selway JS. 2011. Electoral reform and public policy outcomes in Thailand: the politics of the 30-baht health scheme. *World Politics* 63: 165–202.
- Slater D. (2010). *Ordering Power: Contentious Politics and Authoritarian Leviathans in Southeast Asia*. New York: Cambridge University Press.
- Steinmo S, Watts J. 1995. It's the institutions, stupid! Why comprehensive national health insurance always fails in the US. *Journal of Health Policy, Politics, and Law* 20: 329–72.
- Sparkes SP, Bump JB, Reich MR. 2015. Political strategies for health reform in Turkey: extending veto point theory. *Health Systems & Reform* 1: 263–75.
- Tsebelis G. (2002). *Veto Players: How Political Institutions Work*. Princeton, NJ: Princeton University Press.
- Wong J. (2004). *Healthy Democracies: Welfare Politics in Taiwan and South Korea*. Ithaca, NY: Cornell University Press.