

## REVIEW ARTICLE

# The Political Economy Influence on Health Policy Reform in Malaysia: The Policy Analysis and Evaluation of '1Care for 1Malaysia'

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## ABSTRACT

Health systems worldwide face challenges in implementing intentional reforms due to intricate political economies shaping healthcare policies. Malaysia's dual system of tax-funded public care and out-of-pocket private financing reflects these complexities. Despite numerous attempts over the past three decades, Malaysian policymakers have struggled to transition to a unified insurance-based system. The "1Care for 1Malaysia (1C1M)" initiative in 2010 aimed to overhaul Malaysia's healthcare policy but faced challenges such as inadequate political will, financial constraints, stakeholder opposition, and policy ambiguity. This review employs the policy analysis triangle and the policy cycle framework to analyse 1C1M comprehensively. Despite its goals of achieving universal health coverage (UHC) and enhancing efficiency and equity, the initiative was hampered by political prioritisation issues, public skepticism, and management instability. Lessons from international experiences highlight the importance of sustained political commitment, transparent communication, and stakeholder engagement in driving successful reforms. Future efforts in Malaysia must prioritize these elements to achieve sustainable healthcare improvements.

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## INTRODUCTION

Health systems are notoriously difficult to change intentionally, primarily due to the intricate political economy of health. Political economy in the context of health policy reform, refers to the study of how political and economic element interact to form policy decisions and outcomes. This method analyzes the distribution of power, resources, and interests among various stakeholders, such as governments, healthcare providers, insurance companies, private service provider and general public (1). Unlike other sectors, such as education and social services, health systems are fundamentally the creation of health professionals. The most enduring features of health systems originate from how medical professions, mainly, collectively organise the delivery of health services. This unique characteristic

underscores the complexity of implementing health policy reforms (2, 3).

On several occasions over the past 30 years, Malaysian policymakers have attempted to transform the existing hybrid system in which tax-funded, publicly provided care coexists with largely out-of-pocket financed private care into a unified insurance-based system. Despite these efforts, each proposal was defeated. This persistent failure is notable given that 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 (4, 5).

Reforming health policies is essential to the development and long-term viability of healthcare systems across the globe. In Malaysia, the introduction of the "1Care for 1Malaysia (1C1M)" reform initiative in 2010 marked a significant milestone in the nation healthcare policy landscape. This review provides a comprehensive analysis of the 1C1M initiative through the lens of

established policy analysis frameworks.

The policy analysis triangle introduced by Walt and Gilson in 1994 is central to this analysis, and it will serve as the primary methodological tool (6). This framework facilitates an in-depth examination of the complex interrelationships that underpin health policy reform, encompassing the critical dimensions of context, content, process, and actors. In addition to the policy analysis triangle, the policy cycle framework proposed by Buse et al. will be employed. This policy cycle framework is a comprehensive approach that divide the policy process into multiple stages which is agenda setting, policy design, implementation, and evaluation. This supplemental framework ensures a thorough and comprehensive study by taking into consideration Malaysia's specific economic, social, and political situations. It allows for a more sophisticated diagnosis of the political economy features and core causes of health-care crises, which guides policy formation, implementation, and assessment (7, 8).

This research seeks to give an informed assessment of the 1C1M health policy change and its complex link to Malaysia's healthcare sector (9). By digging into the political economics environment of the reform initiatives, the analysis will critically evaluate the outcomes of the 1C1M program and make recommendations for future improvements.

## POLICY ANALYSIS

### Context

Malaysia is an upper-middle-income country (10) in Southeast Asia and is geographically divided by the South China Sea into two main regions: Peninsular Malaysia and East Malaysia (11). As a federal constitutional monarchy, Malaysia is composed of a federation of 13 states and three federal territories: Kuala Lumpur (the capital), Putrajaya (the federal government center), and Labuan (12). Malaysia's unique multiracial profile is shaped by three main ethnic groups: Bumiputra (62.4%), Chinese (17.9%), and Indian (9.5%) (13). Malaysia's political landscape is heavily influenced by its ethnic composition, with race-based parties often utilise identity politics for support (14). With a population slightly exceeding 32 million, the life expectancy at birth is 72.7 years for males and 77.4 years for females (15, 16). Malaysia is forecasted to attain an aging population status by 2035, with an estimated 15% of the total population aged 60 and older (17, 18).

Since achieving independence in 1957, Malaysia has maintained a healthcare system comprising public and private financing and service delivery that operates under a National Health Service (NHS) or Beveridge health model (19), with healthcare organised and largely funded from public tax revenue (20, 21). This dual system has achieved remarkable milestones while

operating with a national expenditure below the WHO-recommended 5% GDP threshold for healthcare annually (22). In 2022, Malaysia allocated RM 30.625 billion (10.5 billion USD) to healthcare, amounting to 2.3% of its GDP. However, when we look at the breakdown of healthcare spending, it reveals that RM28.03 billion was used for the operation budget and RM4.38 billion for development budget. Significant portion is allocated toward operational costs, rather than new developments or expansions in healthcare infrastructure (23). However, as compared to middle- and high-income nations worldwide, Malaysia's healthcare spending is still relatively low (24). The public sector provides a wide range of services, from basic and preventative care to tertiary hospital care. In order to preserve a sizable market share in the healthcare industry, Malaysia's Ministry of Health (MOH) serves as the primary financier, supplier, and regulator of healthcare services (25). The private sector, which is mostly found in cities and functions with little supervision, makes money primarily from fee-for-service, patient out-of-pocket (OOP) payments, and a growing dependence on private insurance plans (26-28).

### Content

In 2009, the government proposed a concept paper called '1Care 1Malaysia (1C1M): Restructuring the Malaysian Health System' (29), intended to give Malaysians comprehensive health coverage and to revamp Malaysia's healthcare system by replacing the existing tax-funded model from the NHS with a mandatory Social Health Insurance (SHI) scheme with fixed premiums (16, 30). OOP and Private Health Insurance (PHI) are proposed for top-ups and co-payments, although specific rates remain unspecified. The '1C1M' policy was intended to put forward the Universal Health Coverage (UHC) agenda to enhance equitable access and improve healthcare infrastructures to ensure fairness for all citizens, including the poor (31). This policy link closely to the goals set in the 10th Malaysia economic plan, which stress out the importance of restructuring healthcare to address accessibility and equity across the country (31). The goals of 1C1M include 1) Universal health coverage (UHC) for all Malaysians; 2) An integrated healthcare delivery system with a thrust on primary health care; 3) Provision of affordable, efficient, and sustainable health care; 4) An equitable health system in terms of both access and financing; and 5) A streamlined MOH focused on governance, stewardship, and public health services. This scheme is intended to optimise available resources to deliver care across programs, healthcare settings, and providers based on the criteria outlined in the World Health Organisation (WHO) cube diagram for UHC (32). Under the leadership of Prime Minister (PM) Najib Tun Razak at the time, his political agenda of making massive changes in the Malaysian healthcare systems triggered this reform. In accordance with PM Najib's vision of 1Malaysia and the political objective of

the ruling coalition at the time, the 1C1M was justified on the grounds of "solidarity," "fairness," and "equity" (28). PM Najib created the political slogan 1Malaysia to encourage national cohesion, ethnic peace, and effective government.

### Process

Following the 12th general election in 2008, 1C1M was implemented. However, it was dropped prior to the 2013 election. These two-election related turning points are important indicators for examining the reform course. With just 51% of the general vote and a two-thirds majority in parliament, the 2008 election, dubbed a "political tsunami," signalled a sharp drop in popularity for the incumbent Barisan Nasional (BN) coalition, which allowed PM Najib to take over as prime minister in April 2009 (33).

The National Health Financing (NHF), MOH, was tasked with drafting the 1C1M concept paper in 2009 (16). The first public announcement of 1C1M coincided with the "10th Malaysia Plan 2010-2015" presentation in February 2010 (31). This announcement formed 11 Technical Working Groups (TWGs) on 1C1M, which explored various aspects such as service delivery, governance, financing, and human capital. In October 2010, PM Najib officially introduced Malaysia's 1C1M reform during an address to the WHO Regional Committee for the Western Pacific.

### Stakeholders and actors

The interests of actors and stakeholders involved in the 1C1M health policy reform span political, financial, bureaucratic, ideological, consumer protection, and provider choice and quality interests (16). Additionally, coalitions have been formed against 1C1M, demonstrating stakeholders' power and effectiveness in promoting their stance on the reform. Pertinent stakeholders in health sector reform encompass entities within and outside the government. The main internal stakeholders, which is the Prime Minister and Health minister were crucial in setting up the reform agenda and gaining political support. The Ministry of Finance (MOF) as a major enabler in government developed a financial structure and allocate resource for the implementation. Other economic bodies such as the Central Bank, Economic planning unit contributed by evaluating the macroeconomic effect of the changes. External stakeholders such as opposition political parties utilize the reform to critique and express concern to gain public support. Professional associations representing healthcare workers voice their concerns about potential impact on service delivery. Industry representatives, especially from the private sector, expressed concern about potential financial problems. Academics and researchers provide evidence-based criticism and policy alternatives. This combination of multiple stakeholder's environment shows the complexity of 1C1M reform. It also highlights the difficulties in balancing the conflict of

interest and attaining policy unity (16).

### Power Relations and Institutional Barriers

The introduction of 1C1M was heavily influenced by the political agenda of Prime Minister Najib Tun Razak. The formation of coalitions from stakeholder opposing 1C1M shows that their strength and effectiveness in promoting their stances on their reform agenda. By analyzing these coalitions, it reveals that there is underlying power dynamics and conflicts of interest among stakeholders. The institutional framework, including the Ministry of Health (MOH) role as the financier, provider, and regulator, highlight that the bureaucratic processes that might inhibit quick decision making and responsiveness to stakeholder concerns (35).

### Economic Ideologies

The 1C1M policy proposed a shift from a purely tax funded model to a mixed model involving social health insurance. This change reflects an economic ideology that seeks to balance public and private financing mechanisms to ensure sustainable and equitable healthcare. However, the current financing mechanism, which subsidizes up to 98% of patients' costs, is seen as unsustainable and in need of reform (35).

## POLICY EVALUATION

### Effects and evaluation of the health policy reform

The implementation of the 1C1M scheme sought to address critical gaps in Malaysia's healthcare system by significantly increasing healthcare funding and expanding infrastructure. Under the 1C1M scheme, the 2014 healthcare budget of RM 22.1 billion (USD 5.3 billion ) has been allocated to improve access to healthcare infrastructure and services across Malaysia (36). Additionally, the number of public hospitals had risen to 147(36). The government has also approved the construction and upgrading of hospitals, establishing 284 1Malaysia primary clinics (31) and adding 2000 parking spaces at the General Hospital Kuala Lumpur (34). This 1Malaysia Clinic is categorize as type 6 and 7 where the average daily attendance range between 50 to 100 patients per day, with the service provided is only cover for minor illnesses and simple procedures for the outpatient services (31). A total of 6800 additional nurses were appointed to improve nursing care quality (34). The budget allocation also accounted for the financial support and upgrading of rural and Orang Asli (aborigines) living standards and procurement of equipment and medicine to ensure proper patient treatment, alongside the expansion of cardiothoracic services in major cities (34). The 1C1M scheme ranges from policy implementation on disease prevention, such as the abolishment of sugar subsidy in 2013 (31); immunisation services; and mammogram screening, to rehabilitative programs like providing free breast prostheses; and continuous ambulatory peritoneal dialysis kits for home treatment (34).

**Necessary improvements for future reforms**

***The lack of transparency, inadequate goal setting, and strategy formulation*** surrounding the details of the 1C1M proposal raise concerns among Malaysians (16, 37). There were unclear specifics about SHI in the 1C1M concept paper (16). Concerns have been raised regarding further payments into an undisclosed fund, the creation of an unaccountable organization vulnerable to corruption and cronyism, and the possible harm that privatization may do to the effectiveness and affordability of healthcare. Because of the government's lack of strategic communication and public debate, 1C1M fall apart. Thus, allowing it open to criticism and assaults from opponents who took advantage of its uncertainties (16). From policy evaluations of high-income nations (37, 38) and low-income nations (34), inadequate goal setting and an unclear path to reform implementation can further hinder the success of reform efforts. The proposed policy fix must be clearly articulated, backed up by data pertaining to the identified problem, and persuasively communicated. The government should prioritize transparency and communication by providing accurate and comprehensive information about the proposed reform (38, 39). This ambiguity increased public apprehension about additional payments and the impact of privatization on healthcare costs and effectiveness. Due to the government's lack of strategic communication and public discussion, opponents were able to capitalize on these ambiguities and undermine support for the move.

***Reformers' unrealistic or wrong viewpoints*** may cause reform failure (39). There was a misconception that 1C1M would immediately reduce government spending on health (16). Additionally, the MOF and other economic agencies hesitated to increase health allocations due to budgetary constraints (16). There is a prevailing perception within the MOF and other economic agencies that health expenditure solely burdens the government budget without significant economic contribution. The concept paper estimated an increase in government health expenditure from 2.11% to 2.85% of GDP under 1C1M. The lack of ideological change among the PM and senior economic policymakers restricted substantial boosts in budget allocations for the health sector, thereby limiting reform possibilities (5). Reformers with key stakeholders must have realistic and accurate viewpoints by ensuring that the projected outcomes of the reform align with the actual expectations (40). Considering the global context, it is obvious that successful health financing reforms in other countries have overcome similar challenges through clear communication, transparent goal-setting, and robust public engagement. For example, rather than depending on short-term cost reductions or irrational financial estimates, the health insurance reforms in Taiwan and South Korea were successful because they progressively increased political consensus and public confidence over time (41). The financial advantages of

investing in health care must also be acknowledged by legislators. Health spending is an important investment in the nation's human capital and economic growth, not only a financial burden. Gaining the political will and dedication needed for effective health policy reform requires this ideological change. The reform's anticipated results must match real expectations, and ongoing assessment and observation are required to spot veering off course early on. This makes it possible to make the required changes quickly, guaranteeing that the reform stays in place (39, 42).

***Lack of political will.*** The health system reform process is inherently political and often controversial (39). The ruling coalition and PM Najib did not prioritise 1C1M as a key political agenda and lacked political will, resulting in its failure to gain significant traction in the public sphere. Reform requires strong political backing and the dedication of policymakers. Failure usually came from the government's own failure to prioritize and consider reform initiatives (43, 44). Furthermore, the political landscape in Malaysia which is marked by frequent changes in party affiliations and the predominance of party-driven agendas, made it challenging to promote political agreement on healthcare reform. In Malaysia, policymakers had sometimes hesitated to take controversial stances that would offend influential interest groups like insurance corporations and private healthcare providers, especially those in the ruling coalition. The government unable to enact a meaningful health system reform was due to constraint by these organizations strong political influence (45–46). It is critical to realize that changes to the health system require sustained political support and sustained dedication, which can be challenging in a shifting political environment. Politicians are less inclined to support long-term health projects that may not provide immediate advantages due to the short electoral cycles and the emphasis on short-term political gains. This entails building broad political agreement on the importance of health reforms and ensuring that health policy remains a top issue over several election cycles. Policymakers must also develop and implement strategic communication strategies that are clear and effective to involve stakeholders and the public and build broad support for the reforms.

***The financial challenges faced by Malaysia's healthcare sector played a significant role in the failure of the 1C1M reform.*** At 4.55% of GDP in 2010, Malaysia healthcare spending falls below levels in countries with comparable economic development. Less than 10% of the federal budget and around 2.32% of GDP are allocated to health by the government, it is notably lower than global targets like the Abuja target of 15% (47) and the 5% of GDP recommended by experts (48). At 56.7%, government spending made up the greatest share, followed by private health insurance at 6.5%. This excessive dependence on out-of-pocket

expenses puts a great deal of financial burden on people and may result in unequal access to healthcare. Malaysia spent around RM 9.47 billion (USD 2.95 billion) on out-of-pocket (OOP) medical expenses in 2010, which accounted for about 35.2% of all medical expenses (49). Coupled with limited involvement of social security funds in mitigating catastrophic health expenditure, led to the conclusion that Malaysia's health financing in the 1C1M scheme resembled a lower-middle income country rather than a nation striving for high-income status by 2020. These figures underscore the underlying issue and shed light on why the reform, 1C1M, faced challenges that aimed to address future issues rather than immediate needs. Indeed, financial pressures on healthcare are a global issue (39, 50). It becomes clear that the financial structure of Malaysia's healthcare system is not conducive to sustainable reform. The low government spending on health relative to GDP and the federal budget constrains the ability to implement comprehensive reforms. This situation is exacerbated by a reliance on OOP spending, which places a heavy financial burden on individuals and can lead to inequities in access to healthcare service. Lower income households face a higher rate of health expenditure with costs exceeding substantial amount from their income. Geopolitical disparities also aggravate the issue as rural and undeserved areas often had to incur extra cost for accessing private health care due to limited public health infrastructure. Additionally, the government has to come up with a comprehensive plan for health financing that includes higher social security payments and involvement in commercial health insurance (49). Malaysia can build a more robust and fair healthcare system by lowering the financial load on citizens and diversifying financing sources. Malaysia may create more efficient and long-lasting health policy reforms by taking inspiration from other countries, such as Germany and France (51), and attending to the urgent budgetary requirements of the healthcare system. To provide fair access to healthcare for all Malaysians, this strategy will call for more government health appropriations, wise use of social security money, and lower OOP spending.

***The challenges of policymaker and management instability, compounded by structural hurdles, significantly undermined the 1C1M reform initiative.***

The MOH made an attempt to reduce misunderstandings and rally support, but criticism remained. In the run-up to the 2013 general election, 1C1M lost support. The idea was not specifically included in the ruling BN coalition election manifesto, indicating that healthcare reform was not given enough attention during the campaign. With BN losing the popular vote for the first time and making a two-party system a permanent fixture in Malaysian politics, this election signalled a dramatic political shift. As a result, 1C1M was not actively pursued thereafter, while opposition parties sometimes brought up the topic again for political purposes. Because Malaysia is a democratic country, changes in leadership can have

a big influence on how reform initiatives proceed (52). Frequent shifts in the political environment, management instability, and new leaders' unfamiliarity with ongoing reform initiatives pose significant obstacles to sustained progress (53-56). These challenges highlight the need for continuity and long-term commitment to healthcare reform efforts, regardless of changes in political leadership, to ensure the successful implementation of policies and initiatives aimed at improving the health system. Drawing from international examples, countries that have successfully implemented healthcare reforms, such as the United Kingdom's NHS reforms under different political administrations, emphasize the importance of bipartisan consensus and institutional stability (57). These countries have demonstrated that sustained political commitment and cross-party collaboration are essential for overcoming the inherent challenges of healthcare reform. In Malaysia, overcoming the barriers posed by political volatility and leadership transitions requires strategic foresight and bipartisan engagement. Future healthcare reform initiatives must prioritize building broad-based political support and ensuring institutional stability to guarantee continuity beyond electoral cycles. This approach will help mitigate the disruptive effects of political changes and ensure that reform efforts remain on course to improve the resilience and effectiveness of Malaysia's healthcare system.

## CONCLUSION

The complex relationships among the political, economic, and social aspect of the population and their effects towards the general wellbeing of society must be taken into account while implementing policies. For policies to be implemented effectively, a thorough understanding of the complicated relationships is required. Health, unfortunately was ultimately not a top concern for the public or the government, at least in the case of 1C1M. The main obstacle was still political. It is crucial for aspiring public health advocates to recognize the value of being involved in politics by learning about the political economy and identifying areas where health policy reform may succeed in the future. The 1C1M also highlights the need of integrating social, political, and economic strategies to create strong health systems that prioritize equity and universal access. By adopting a proactive and cooperative approach, Malaysia may overcome these obstacles and create a healthcare system that can satisfy the needs of a society that is changing quickly.

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