Systemic Discrimination and its Effect on Healthcare in Malaysia: Causes, Implications, and Plausible Solutions

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Introduction

With nearly a third of its 32 million citizens belonging to one or more ethnic identity (including Chinese, Indian, non-Malay Bumiputera, and Orang Asli Indigenous groups), Malaysia is one of the most ethnically diverse countries in the world.[1][2] However, its deeply entrenched racial hierarchy continues to create significant social, economic, political, and legal challenges for ethnic minorities.[3] The concept of *Ketuanan Melayu,* which literally translates to "Malay Supremacy," has historically created strong preferential treatment for ethnic Malays in various sectors of society, leaving minority ethnic groups facing significant wealth, human rights, health, and many more disparities.[4] From a health and healthcare perspective, *Ketuanan Melayu* is a significant and primary influence on minority populations' access to and quality of health services due to its large influence on social determinants of health, including worsening working and living conditions, social exclusion, and income inequality, which are disproportionately impacting ethnic minorities in Malaysia. With nearly 10 million citizens belonging to one or more minority ethnic groups in Malaysia,[5] preferential treatment in healthcare on the basis of ethnicity negatively impacts the health and well-being of an overwhelming number of people and poses a significant obstacle to improving global health, social determinants of health, and health equity.

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[1] "Population Distribution and Basic Demographic Characteristic Report 2010 (Updated: 05/08/2011)." *Department of Statistics Malaysia Official Portal*, 8 May 2011, https://www.dosm.gov.my/v1/index.php?r=column%2Fctheme&menu_id=L0pheU43NWJwRWVSZklWdzQ4TlhUUT09&bul_id=MDMxdHZjWTk1SjFzTzNkRXYzcVZjdz09.

[2] "Malaysia." *Malaysia - Place Explorer - Data Commons*, https://datacommons.org/place/country/MYS?utm_medium=explore&mprop=count&popt=Person&hl=en.

[3] Klitgaard, R., & Katz, R. (1983). Overcoming ethnic inequalities: Lessons from Malaysia. *Journal of Policy Analysis and Management*, *2*(3), 333–349. https://doi.org/10.2307/3324445

[4] Gomez, E. T., & Saravanamuttu, J. (2013). *The New Economic Policy in Malaysia: Affirmative action, ethnic inequalities and social justice*. NUS press.

[5] Hirschmann, R. "Malaysia: Breakdown of Population by Ethnicity 2021." *Statista*, 10 Aug. 2021, https://www.statista.com/statistics/1017372/malaysia-breakdown-of-population-by-ethnicity/.

In recent years, awareness about the consequences of *Ketuanan Melayu* on ethnic minorities in Malaysia, particularly with regards to human rights, have been raised.[6] Impacts on healthcare access, however, remain highly unexplored, despite evidence that Malaysian minorities face significant structural barriers when attempting to access healthcare, such as higher medical fees, racism from healthcare professionals, and xenophobia.[7][8] The Malaysian government has not, historically, explicitly acknowledged the unequal treatment of different ethnic groups in the healthcare system, evidence revealing disproportionate, ongoing rates of ill health in regions with dense minority populations strongly suggest that systemic, ethnic barriers have been permitted to persist for decades.[9][10]

Despite the severely negative impacts that poor access to healthcare has on millions of people, very little has been done to improve the social determinants of health, including access to healthcare. Likewise, discriminatory healthcare policies in Malaysia such as exclusionary practices that restrict ethnic minorities from accessing Malaysia's best health clinics and little government funding allocations to the development of care facilities in rural areas continue to

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[6] *World Report 2020: Rights Trends in Malaysia*. Human Rights Watch. (2020, January 16). Retrieved November 30, 2021, from https://www.hrw.org/world-report/2020/country-chapters/malaysia#.
[7] Saleh Ibrahim, Y. (2015). *Ethnic Affiliation and Access to Affordable Healthcare in Nigeria and Malaysia*. Universiti Utara Malaysia.
[8] Mariapun, J., Ng, C.-W., & Hairi, N. N. (2018). The gradual shift of overweight, obesity, and abdominal obesity towards the poor in a multi-ethnic developing country: Findings from the Malaysian National Health and morbidity surveys. *Journal of Epidemiology*, *28*(6), 279–286. https://doi.org/10.2188/jea.je20170001
[9] Lim, Y.A.L. and Romano, N. and Colin, N. and Chow, S.C. and Smith, H.V. (2009) *Intestinal parasitic infections amongst Orang Asli (indigenous) in Malaysia: has socioeconomic development alleviated the problem?* Tropical Biomedicine, 26 (2). pp. 110-122. ISSN 0127-5720
[10] Lin Khor, G. (2008). The Ecology of Health and Nutrition of Orang Asli (Indigenous People) Women and Children in Peninsular Malaysia. *Tribes and Tribals*, *2*, 67–75.

persist.[11][12] This inaction can be attributed to the fact that systemic discrimination, such as Ketuanan Melayu, are deeply ingrained and normalized in Malaysian culture and politics.[13]

Research Question and Impact

This research project sought to answer the following questions: ***how do systemic forms of discrimination, particularly those originating from Ketuanan Melayu, influence access and, to a lesser extent, quality of healthcare for ethnic minorities in Malaysia? What actionable steps can be taken to reduce institutionalized prejudice towards minorities within healthcare?*** Further, it aimed to understand the reasoning, legalities, and application of prejudicial policies in healthcare in order to suggest tangible next steps for various actors, such as nongovernmental and international organizations, to initiate a shift towards greater equality and inclusion in Malaysia's healthcare system. Due to the limited number of existing projects that address either topic, much less in conjunction with one another, this research has the potential to trigger many positive implications, including, but not limited to, future research on health equity in Malaysia and similar middle and underdeveloped countries, systematic policy revisions to address, or at the very least, re-evaluate, barriers to healthcare for ethnic minorities in Malaysia, and the incorporation of historically sidelined perspectives, particularly those of community members, activists, and nongovernmental organizations, in future research and policy.

Background Information

[11] Mohamad Noh, K., & Jaafar, S. (2011). Health In All Policies: The Primary Health Care Approach in Malaysia . *World Conference on Social Determinants of Health*, 3–20.
[12] United Nations General Assembly Human Rights Council. *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Dainius Pūras*, United Nations General Assembly, 2014.
[13] Lee, H.-A. (2017). Majority Affirmative Action in Malaysia: Imperatives, Compromises, and Challenges. *Global Centre for Pluralism*, 1–24.

I. Ketuanan Melayu and Race Relations

Ketuanan Melayu, which literally translates to "Malay supremacy" or "Malay overlordship," is a concept widely applied in many, if not most, aspects of Malaysian society and life.[14] In brief terms, it is a system of affirmative action that emphasizes the prioritization of ethnic Malays in aspects such as the medical system, the education system, housing, social services, and so forth. The strong adherence to Malay preeminence is largely motivated by a desire to preserve the Malay identity and culture: although Malaysia is home to many generations of Chinese and Indian immigrants and form a significant minority of Malaysia's population, they are considered beholden to Malays under Article 153 of the Constitution of Malaysia. Known as the "Malaysian social contract," it prescribes an agreement that, in exchange for citizenship in Malaysia, immigrant populations will not have the same exceptional rights as ethnic Malays.[15] Ketuanan Melayu is often used by professionals and politicians, especially from the United Malays National Organization (UMNO).[16]

Ketuanan Melayu has been met with vocal political opposition, particularly from non-Malay political parties and immigrant and/or ethnic minority populations in the country.[17] Historically, there have been numerous efforts to advocate against ketuanan Melayu: in the 1960s, Singapore (which was a state in Malaysia from 1963-65) led a substantial effort challenging Malay nationalism, which followed even after Singapore's separation in 1965.[18] Further, the race riots of May 1969 were further efforts to challenge the concept, however it also

[14] United Nations General Assembly Human Rights Council. *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Dainius Pūras*, United Nations General Assembly, 2014.
[15] Ibid.
[16] Ibid.
[17] Welsh, Bridget. "Malaysia's Political Polarization: Race, Religion, and Reform - Political Polarization in South and Southeast Asia: Old Divisions, New Dangers." *Carnegie Endowment for International Peace*, 18 Aug. 2020, https://carnegieendowment.org/2020/08/18/malaysia-s-political-polarization-race-religion-and-reform-pub-82436.
[18] Ibid.

raised strong "ultras" who strongly believed that Malays were the only one, true, definitive people of Malaysia, leading to the New Economic Policy (NEP), a government policy introducing - and entrenching - ketuanan Melayu as it is known today.[19]

Since its implementation, the NEP and aggressive use of ketuanan Melayu has provided exceptional benefits exclusive to ethnic Malays. Examples include discounts on property purchases, lower standards for credit, special business grants, lower standards for loans, preferences in higher education admissions processes, and, most relevant to this project, aspects such as exclusive medical facilities, reduced waiting times, greater prioritization on surgical and transplant waiting lists, and so forth.

II. The Malaysian Medical System

Healthcare in Malaysia is administered by the Ministry of Health, operating under a two-tier healthcare system in which the government provides a basic, universal healthcare system in addition to a private healthcare system.[20] Most specialist services are accessed through the private healthcare system, due to extensive queuing when provided by the universal healthcare system.[21]

Compared to most developed countries, the publicly provided healthcare provisions are extremely basic, especially in rural areas where many ethnic minorities, particularly Indigenous

[19] Lee, H.-A. (2017). Majority Affirmative Action in Malaysia: Imperatives, Compromises, and Challenges. *Global Centre for Pluralism*, 1–24.
[20] "ICT Project in Malaysia - A Case of Public-Private Partnership." *Dec. 14-15, 2017 Kuala Lumpur (Malaysia)*, 2018, https://doi.org/10.15242/dirpub.hdir1217220.
[21] Extracted from Key Informant Interviews (2022).

populations, reside.[22] In 2009, the government briefly sought to resolve the disparities between urban and rural access to care with the *1Care for 1Malaysia* policy, which would allow those will lower incomes to pay less for the same public resources, but very little progress has been made to implement the policy, among other similar proposals.[23]

There are a variety of shortcomings in the Malaysian medical system that have been widely criticized by the public and academics. Most notably, publicly accessible hospitals face an extreme shortage of staff in relation to patients, once again, particularly in rural regions with larger densities of minority populations.[24] Private hospitals are predominantly located in urban areas, largely restricting access to the most wealthy, who typically reside in large cities, and belong to ethnic majority (Malay) groups.[25] Most of the latest medical technologies and equipment are only accessible in private hospitals, increasing queues and reducing access to the most vulnerable.[26] There is also a shortage of medical personnel and doctors in Malaysia, who are typically concentrated in urban areas. An area of growing concern is the large number of foreign patients from relatively poorer, less developed neighbouring countries who seek medical care in Malaysia, which further increases wait times and reduces accessibility for ethnic minorities in rural populations.[27] Finally, the shortage of medical staff, particularly in rural regions, has raised concerns regarding the service and delivery of medical information to ethnic minorities who may not speak the same language as medical staff. This is an area of concern

[22] Faller, Erwin Martinez, and Nataman Miskam. "Health Status of Migrant Workers Attending Primary Care Clinics in Malaysia: Basis for Health Intervention Programme." *Faculty of Public Health - Andalas University - OCS*,
[23] Lasimbang, Helen Benedict, et al. "Migrant Workers in Sabah, East Malaysia: The Importance of Legislation and Policy to Uphold Equity on Sexual and Reproductive Health and Rights." *Best Practice & Research Clinical Obstetrics & Gynaecology*, vol. 32, 2016, pp. 113–123., https://doi.org/10.1016/j.bpobgyn.2015.08.015.
[24] Ibid.
[25] Lim, Ka Keat, et al. "Equity in Access to Health Care in a Rural Population in Malaysia: A Cross-Sectional Study." *Australian Journal of Rural Health*, vol. 25, no. 2, 2016, pp. 102–109., https://doi.org/10.1111/ajr.12298.
[26] Ibid.
[27] Extracted from Key Informant Interviews (2022).

especially for Indigenous groups, many of whom speak languages that are distinct from Malay, Chinese, and Tamil, the languages most predominantly in use in most available medical facilities.[28]

Methodology

This project spanned six weeks between July 4th and August 12th, 2022. The methodology began with a systematic review of documentation (e.g. legislation, government documentation) and review of existing literature in relation to *Ketuanan Melayu*, race, health policy, and social determinants of health. Following the document and literature review, the findings were supplemented by key informant interviews with medical professionals, government officials, nonprofit and nongovernmental organizations, activists, locals, and more relevant members of civil society. A particular focus, both during the literature review and interview process, was placed on the relationship between *Ketuanan Melayu* and social determinants of health that influence access to healthcare, such as racism. Determinants of health in various geographical and ethnographic regions were further to compare the healthiness of regions with various densities of minority populations. In addition, federal, state, and local legislation for regions with varying minority populations were compared to deduce if there were any differences in health policy and standards. This data was drawn to highlight the felt impact of government policy on predominantly minority communities.

The consultations with stakeholders detailed above were conducted virtually in August 2022 to best navigate dynamic COVID-19 changes and budget restrictions while retaining the international and interdisciplinary scope of the research. To ensure diverse perspectives were

[28] Extracted from Key Informant Interviews (2022).

maintained, community members that were more difficult to reach virtually, such as Indigenous groups, were represented by consultations with stakeholders such as nongovernmental, non-profit, and volunteer organizations that worked closely with said minorities in lieu of community members personally. A total of 21 key informant interviews were conducted with 25 total participants (2 of the key informant interviews were done with pairs of interviewees) representing 5 global universities, 4 non-profit organizations, 2 law firms, 4 non-profit and/or non-governmental organizations, the Malaysian Ministry of Health, and 3 international governance organizations.

Each key informant's responses were recorded on an interview guide. Responses were then anonymized by assigning a random, unique participant code to each interview guide and destroying any record of identifying information. Following this, each guide was run through a qualitative analysis protocol in NVivo containing codes for specific themes, which was utilized to classify and sort the data into key themes and filter what was most critical and predominant. The relationships between various topics and themes were also analyzed using NVivo.

Following the key informant interview process, all data was stored in a highly secured platform accessible only to the principal investigator.

Key Findings

I. The Relationship Between Race, Ethnicity, and Various Social Determinants of Health

There is a clear relationship between ketuanan Melayu, and thus race relations, and a multitude of social determinants of health (SDOH) in Malaysia. Most notably, the SDOH with the strongest causation and/or correlation to race and ethnicity in Malaysia consisted of racism (including microaggressions, stereotypes, persistent stigmas, and so forth) and preferential treatment in medical systems and facilities, geographic disparities, such as differences in access to healthcare facilities and government priorities in urban development.

It is crucial to note that these SDOH are by no means exhaustive. Through both the literature review and discussions with key informants, it was discovered that a multitude of other social determinants, such as stigma towards mental, psychological, and certain physiological illnesses, aging and ageism, access to quality educational and professional opportunities, quality of food and water, and ecological factors were also of key importance in terms of health equity, or lack thereof, for Malaysia's ethnic minorities. However, in the interest of time, this paper will primarily focus on the two aforementioned SDOH.

A. Racism and Preferential Treatment in the Medical System

As prefaced, the sociopolitical concept of ketuanan Melayu, which has only been further engrained and accepted in Malaysian society since the instation of the New Economic Policy (NEP) in 1971,[29] has created racial hierarchies that prioritize ethnic Malays in many aspects of society, including the medical system. Access to the country's top facilities and doctors, time

[29] Yu, Chai Ping, et al. "Reform towards National Health Insurance in Malaysia: The Equity Implications." *Health Policy*, vol. 100, no. 2-3, 2011, pp. 256–263., https://doi.org/10.1016/j.healthpol.2010.10.018.

spent on waiting lists (i.e. surgical, transplant, donation recipient), prescription times, and more are only some of the many racially-influenced decisions made in the medical system.[30]

However, the general consensus among existing literature remains that the federal government and Malaysian Ministry of Health have done very little to eradicate racism and active discrimination for patients belonging to ethnic minorities. In most cases, racism is enacted during an interaction between doctor and patient.[31] Due to decades of socially accepted race-related practices in healthcare, such as, but not limited to, restrictions on particular religions (i.e. the inability to practice Muslim faith, except for Sunni sects), the allowance of child marriage and deportation of ethnic migrants, and, in certain cases, permissions to deny private healthcare services on the basis of race, many doctors have become accustomed to prioritizing Malay patients above patients of other racial or ethnic backgrounds.[32] In fact, 6 of 21 key informant interviews reported that either they themselves or colleagues in medical practices had become strongly accustomed to such practices that they became "second nature" and "generic practices without hesitation."[33] These key informants cited that racial discrimination against patients of ethnic minorities ranged from minor disparities, such as filing prescriptions after Malay patients or rescheduling appointments to accommodate a Malay, "more important" patient, to larger inconsistencies, such as moving surgical operation dates and times to denying services for a patient belonging to an ethnic minority but accepting a Malay patient for identical services.[34] Although most instances of race-related, discriminatory practices may appear smaller

[30] Extracted from Key Informant Interviews (2022).
[31] Yunus, Raudah Mohd, et al. "The Need to Map Existing Health Care Services for Refugees in Malaysia." *Journal of Global Health*, vol. 11, 2021, https://doi.org/10.7189/jogh.11.03024.
[32] Ibid.
[33] Extracted from Key Informant Interviews (2022).
[34] Extracted from Key Informant Interviews (2022).

in scale, it is critical to recall there are over 10 million individuals belonging to one or more ethnic minorities, creating a profound net impact. Further, the lack of regulation or laws to reduce the number of racially discriminatory practices, in addition to the lack of culturally-sensitive training for medical professionals, has allowed discriminatory behaviour to continue and flourish without much afterthought.[35] Without proper intervention, such practices will only continue to be normalized and become more drastic in scale and severity.

4 key informants also noted that Indigenous groups, particularly on the coasts of Malaysia, were most prone to racist practices in healthcare and microaggressions due to perceptions of Indigenous groups as "uneducated" or "unknowledgeable" about health and healthcare systems.[36] In Malaysia, medical students and medical professionals are not required to undertake language or cultural training: as such, the stereotypes that revolve around Indigenous groups, such as being "savages" or "knowing only of herbs and essences to heal" have been perpetuated for decades.[37] Further, only an estimated 3-5% of practicing medical professionals had working fluency in native Indigenous languages, leaving significant communication barriers between medical professionals and Indigenous patients, in turn worsening mutual respect and understanding.[38]

B. *Geographic Region and Access to Healthcare Facilities*

Malaysia's medical system is ranked as one of the best in developing and emerging countries, particularly in Southeast Asia, however this title is largely isolated to the country's

[35] Extracted from Key Informant Interviews (2022).
[36] Extracted from Key Informant Interviews (2022).
[37] Extracted from Key Informant Interviews (2022).
[38] Extracted from Key Informant Interviews (2022).

major urban cities.[39] Cities such as Kuala Lumpur, Seberang Perai, Petaling Jaya, and Johor Bahru, which is also where the largest proportion of ethnic Malays reside in proportion to ethnic minority populations, boast Malaysia's cutting edge hospitals, staff, research facilities, medical equipment, diagnostic equipment, and much more.[40] In addition, these regions feature an abundance of private medical facilities and equipment accessible to those who are approved - and have the resources to afford - privatized healthcare. However, regions, districts, and cities in the rural, southern half of the peninsula, such as Selangor, Negeri Sembilan, and along the coastal regions feature the exact opposite: often, there are only a number of dispersed, lower-grade facilities accessible to locals and little to no privatized facilities. According to one key informant from the Department of Statistics Malaysia, urban regions in Malaysia can have as many as 1 doctor for every 150 residents: however, in the most rural areas, often with *the most Indigenous or ethnic minority populations,* there can be as little as 1 doctor for every 1,000 residents. In addition, while most residents of urban areas can access a general hospital within a 15-20 minute commute (or less), residents of the most rural regions may travel up to 3-4 hours before reaching an acceptable-grade facility, often in one of the larger cities.[41] In extreme, but unfortunately, not rare, cases, patients are not able to commute themselves as there is no viable transport line from a rural district to the closest major city: 5 key informants cited that they had patients who were forced to wait for government transport, via ambulance or airlift, to arrive to the patient *and then* travel to the nearest urban region.[42] 7 key informants noted that they had patients who had passed away during the extensive commute - not due to their injuries, which

[39] "World Report 2020: Rights Trends in Malaysia." *Human Rights Watch*, 16 Jan. 2020, https://www.hrw.org/world-report/2020/country-chapters/malaysia.
[40] Ibid.
[41] Yu, Chai Ping, et al. "Equity in Health Care Financing: The Case of Malaysia." *International Journal for Equity in Health*, vol. 7, no. 1, 2008, https://doi.org/10.1186/1475-9276-7-15.
[42] Extracted from Key Informant Interviews (2022).

could have been resolved relatively simply had they arrived to a facility within 1-2 hours, but because of the overbearing time that had elapsed between the incident and their arrival.[43]

Due to the government's strong preference for Malays, most of whom reside in urban, well-off, already developed regions under the concept of ketuanan Melayu, there have been very few policies, regulations, and initiatives designed to improve access to healthcare services for ethnic minorities and populations in rural geographic regions.[44] Notable developments that remain an imminent need, according to 12 key informants, are greater numbers of accessible facilities, both public and private, among suburban and rural regions, a larger distribution of medical staff available at said facilities to attend to patients, and professionals who are able to communicate with patients in a specific region (often Indigenous or minority languages.[45] The government of Malaysia has acknowledged, in passing, the need to improve and expedite the urbanization and development of accessible facilities beyond Malayisa's urban regions: however, the last key development towards this goal was completed in 2002 and has not been advanced, raised, or reintroduced in over 20 years.[46]

It is strongly evident that the relationship between geographic region and access to quality care is resounding. Given the disproportionate number of ethnic minorities who reside in less developed, rural regions as opposed to Malay populations, ethnic minorities are at an inherent disadvantage in terms of accessing a high-quality medical institution or resource in a

[43] Extracted from Key Informant Interviews (2022).
[44] Pereira, Xavier, et al. "Mental Health of Rohingya Refugees and Asylum Seekers: Case Studies from Malaysia." *Intervention*, vol. 17, no. 2, 2019, p. 181., https://doi.org/10.4103/intv.intv_33_19.
[45] Extracted from Key Informant Interviews (2022).
[46] Pocock, Nicola S., et al. "Reflections on Migrant and Refugee Health in Malaysia and the ASEAN Region." *BMC Proceedings*, vol. 12, no. S4, 2018, https://doi.org/10.1186/s12919-018-0100-6.

timely manner. The lack of accessible care has, in turn, resulted in the accumulation of poor health habits that further diminish the health and well-being of minority populations: for instance, 3 key informants cited that ethnic minorities, especially minority groups, were 8 times as likely to skip annual physical check-ups, meet with physicians and other medical service providers (i.e. optometrists, dentists, psychologists, and other specialists) and 15 times as likely to ignore underlying, long-term symptoms due to "lack of time, lack of accessibility, and lack of affordability" to a nearby, affordable, quality facility.[47] The amalgamation of this ignorance can be attributed to the disproportionate rates of cancer, tuberculosis, sexually transmitted diseases and infections, and a vast range of further medical issues among ethnic minorities in rural Malaysia.[48]

II. Recommended Solutions, Policies, and Interventions

There are a number of recommended solutions to resolve the gaps identified in Malaysia's healthcare system that restrict access to quality care for ethnic minorities in the country.

Most notably, and most suggested by key informants, is the development and application of an education system for practicing medical professionals and current medical students revolving around cultural sensitivity, race and ethnic relations, awareness about racism, addressing racism in the medical system, and likewise. Given that many of the key, underlying issues affecting SDOH in the Malaysian healthcare system broadly fall under issues related to racism, poor race-relations, and socially ingrained and acceptable social behaviours that are

[47] Extracted from Key Informant Interviews (2022).
[48] Extracted from Key Informant Interviews (2022).

highly normalized scarcely addressed, implementing a formal type of training and/or education could be the first step to raising awareness and active, conscious thoughts about regular practices and habits when working with vulnerable patients from ethnic minorities. As highlighted by 4 key informants, this type of education system would be ideally developed through a *conjunction* between the Ministry of Health and external non-profit and/or non-governmental organizations that work closely with the populations in question to ensure accountability and transparency.

Further, a significant number of key informants (9) suggested some form of language training, particularly for medical professionals practicing in regions with significant numbers of patients belonging to ethnic minorities to improve communications and the relationship between professional and patient. In a study of 427 patients in rural Malaysia, 66.2% of respondents noted they felt that poor communication with their healthcare provider "set the stage for microaggressions, discriminatory practices, and snide behaviours down the line."[49] This development would be particularly impactful given that language barriers often serve as a foundational basis for trust and transparency between medical professionals and patients. Similarly, this would be best developed though a partnership with the Ministry of Health and relevant civil society organizations.

Third, a notable suggestion included increasing the scope and flexibility of affirmative action to include ethnic minorities, particularly Indigenous groups who are consistently proven to be most disadvantaged by applications of ketuanan Melayu, across *all* sectors in Malaysia. Doing so would allow increased educational and career opportunities for the most vulnerable, underrepresented ethnic minorities in Malaysia and encourage greater amounts of representation

[49] Extracted from Key Informant Interviews (2022).

in the healthcare system. This in turn, argued 3 key informants, would ensure not only a breakdown of the existing language barrier (as aforementioned) but also movements towards acceptance and normalization of diversity, equity, and inclusion in the medical workforce.[50]

Limitations

There were a number of notable limitations experienced during the research process. Most striking was the inability to conduct interviews with local personnel and citizens in Malaysia for a variety of reasons, including the dynamic COVID-19 pandemic and restrictions on international travel and safe conduct of research. Similarly, the reliance on virtual, digital interviews greatly increased the difficulty of interviewing local civilian populations, including Malaysian citizens of various ethnic identities (particularly minority groups), whose lived experiences would have, undoubtedly, contributed vastly to research findings. In addition, these limitations were attributed to the relatively condensed research period of 6 weeks.

In the near future, this project and key findings may be extended to further research translations to increase scope and accessibility.

[50] Extracted from Key Informant Interviews (2022).

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