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

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Research Question

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?

Introduction and Background

With nearly a third of citizens belonging to one or more ethnic identities, Malaysia is one of the most ethnically diverse countries in the world. However, 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 disparities.

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. 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.

In recent years, awareness about the consequences of *Ketuanan Melayu* on ethnic minorities in Malaysia have been raised. 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.

Despitethe 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.

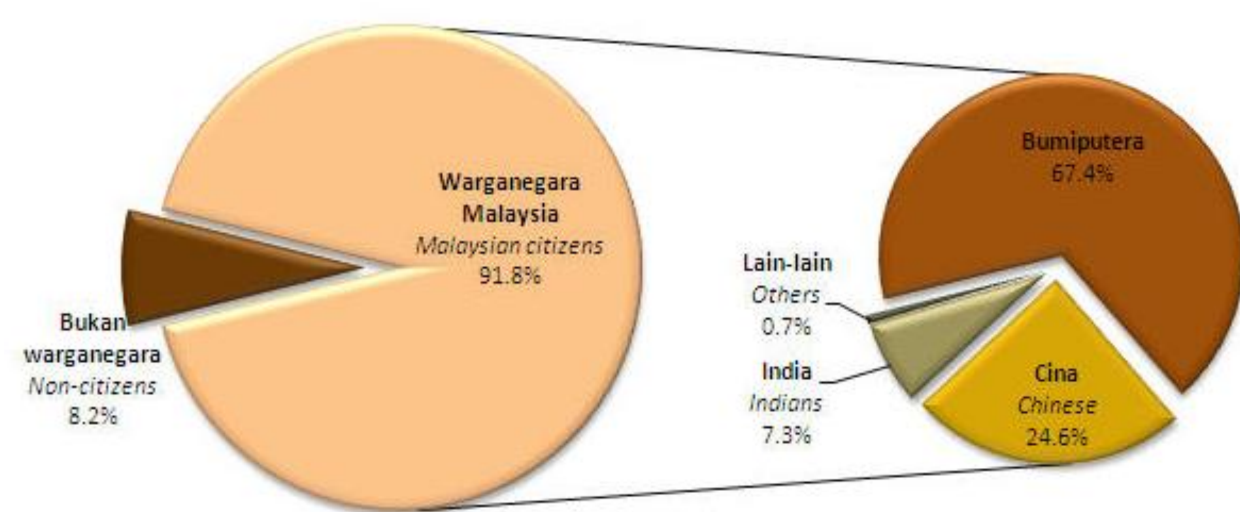

Figure 1. Ethnic Breakdown of Malaysia's Population. (*Source: Department of Statistics Malaysia)*

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Methodology

This project spanned six weeks between July 4th and August 12th, 2022. The research began with a systematic review of documentation and literature in relation to *Ketuanan Melayu*, race, health policy, and social determinants of health. 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.

The consultations were conducted virtually in August 2022. A total of 21 key informant interviews were conducted with 25 total participants.

Each key informant's responses were recorded on an interview guide and then anonymized by assigning a random participant code to each. Each guide was run through a qualitative analysis protocol in NVivo containing codes for specific themes to analyze the relationships between various topics and themes.

Key Findings

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

Ketuanan Melayu has created racial hierarchies that prioritize ethnic Malays in the medical system. Access to the country's top facilities and doctors, time spent on waiting lists (i.e. surgical, transplant, donation recipient), prescription times, and more are some of the many racially-influenced decisions made in the medical system. Due to decades of socially accepted race-related practices in and out of healthcare, many doctors have become accustomed to prioritizing Malay patients above patients of other racial or ethnic backgrounds.

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." 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. 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.

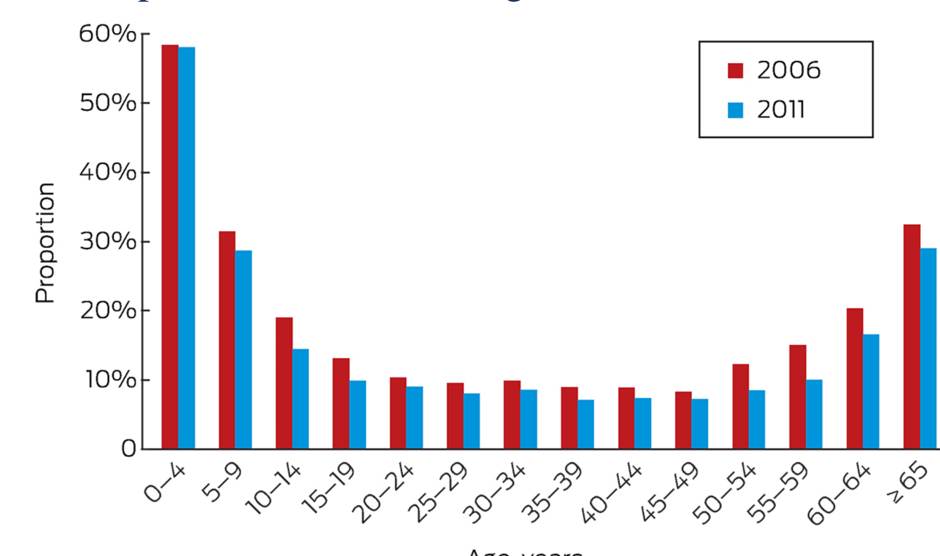

Figure 2. Percentage of Indigenous respondents per age category reporting communications barriers with medical staff.

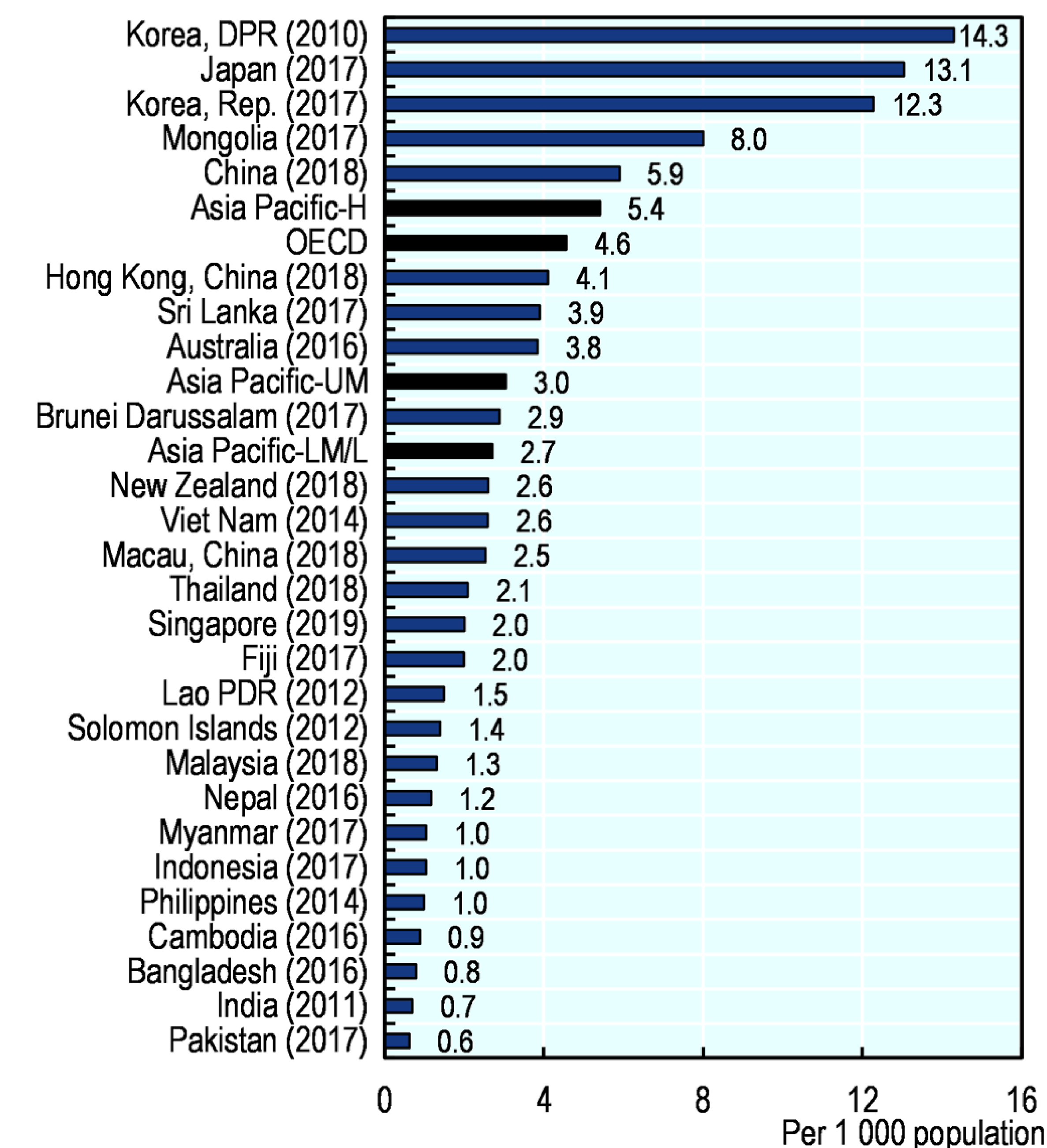

Figure 3. Average number of hospital beds per 1,000 people in Asia. (*Source: OECD)*

Geographic Region and Access to Healthcare Facilities

Urban cities such as Kuala Lumpur, Seberang Perai, Petaling Jaya, and Johor Bahru boast Malaysia's cutting edge hospitals, staff, research facilities, medical equipment, diagnostic equipment, and much more. However, regions, districts, and cities in the rural, southern half of the peninsula, such as Selangor, Negeri Sembilan, and along the coastal regions feature only a number of dispersed, lower-grade facilities accessible to locals and little to no privatized facilities.

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.

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: 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. The amalgamation of this ignorance can be attributed to the disproportionate rates of common medical issues, such as cancer, among ethnic minorities in rural Malaysia.

Key Policy Recommendations

1. Develop 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.
2. Encouragement 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.
3. Increasing the scope and flexibility of affirmative action to include ethnic minorities, particularly Indigenous groups who are consistently proven to be most disadvantaged by of ketuanan Melayu, across *all* sectors in Malaysia, such as in higher education and career advancement opportunities to improve representation and inclusion in all sectors, including healthcare.

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.

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