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A Brief Analysis of the Level of Medical Insurance in Malaysia

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ABSTRACT: Based on the basic theory of health care coverage and using the research methodology of health economics, this study analyses the level of health care coverage in Malaysia based on the ratio of health care coverage expenditures as a percentage of GDP over the past 21 years and actual data from countries around the world. The results show that Malaysia is higher than the average level of South Asia and lower than high-income countries. Finally, based on the current situation of the level of health care coverage in Malaysia, policy recommendations are made to promote health care coverage.

KEYWORDS: Level of medical insurance, total cost of health, Health economics, Economic development, Policy recommendations

I. INTRODUCTION

Medicare is a social system in which a society provides its inhabitants with all health-care services through official and informal institutional structures. Medicare is separated into two categories: wide and narrow. medical insurance, in a broad sense, refers to all institutional or non-institutional arrangements for national health care in a country, including basic social medical insurance, rechargeable medical insurance, social medical assistance, public health prevention and control, medical relief for poor people and regions, and so on; in terms of funding sources, it includes government financial allocations for health, extra-budgetary health expenditures, health expenditures of entitling organisations, and so on. The narrow sense of medical insurance system in countries with insurance-based medical insurance systems, such as the United States, represents social health insurance, which originated and developed from employers in the United States (Blumenthal, 2006); in countries with welfare-based medical insurance systems, such as the United Kingdom and Sweden, it refers to the value of free medical services provided by the state to its citizens, and insurance in the United Kingdom has al The foundation for analysing a country's health-care status is wide medical coverage, and basic medical coverage is the most significant aspect of broad medical coverage.

The entire cost of healthcare ought to be comparable to economic growth from a development standpoint. On the one hand, the level of medical coverage is lower than the moderate space, denying the country's residents the health protection they deserve, and the level of people's health is out of sync with economic development, making it difficult to improve the country's residents' quality of life in the current period. For a single individual, health is generally irreversible, and restoring health necessitates more health resources than preserving health, which is why prevention is preferable to cure. A higher level of health care coverage than the moderate space, on the other hand, will cause the wealth created in a country over a given period of time to be overly allocated to health care, crowding out other areas of expenditure, such as investment and expansion of reproduction, infrastructure construction, and so on. Furthermore, because of the rigidity of people's desire for medical benefits, most welfare-oriented developed countries have found it difficult to manage the amount of social security and medical coverage. There is a limit to how much health can be improved in each time and under specific technological conditions, and the marginal return on health care spending is likewise declining. As a result, determining the wide degree of health care coverage entails determining the appropriate scale of health care cost, which allows for resource allocation that is balanced between maintaining health and preventing waste, as well as the most effective investment of health expenditures.

Medical insurance reform is still underway. The goal is to establish a basic medical insurance system that combines social coordination and individual accounts, covering all urban workers, and then gradually transition to a multi-level medical insurance system that includes basic social medical insurance, supplementary medical insurance, social medical assistance, and commercial medical insurance. The current medical insurance system ensures that every unit of medical insurance investment eventually increases the stock of people's health; there is no waste, and people's health is guaranteed; second, whether the distribution of medical insurance can ensure fairness; whether redistribution of national income is fair; regional differences and urban-rural differences in the distribution of medical insurance resources, and so on. Until recently, Malaysian health care has experienced tremendous transformation. The early pre-colonial medical care was restricted to locally popular traditional cures. Western medical practises were introduced into the nation with the onset of colonisation. Rising earnings and the development of the middle class, as well as

greater urbanisation, have raised demand for and usage of healthcare. International influences and government regulations have also aided the rise of the private sector, resulting in a considerably more complicated health-care system. While primary care is still virtually equally divided between the private and public sectors (in terms of the number of physicians serviced), the hospital sector is experiencing a rapid increase of companies, investor-owned institutions, and the presence of a growing number of specialised clinics (Chee & Barraclough, 2007).

II. LITERATURE REVIEW

Health economics is the study of the operation of the health-care system using economic ideas, methodologies, and viewpoints. It is the study of economic relations and activities in the field of health care as the object of research, with the use of modern applied economic science methods and strategies as tools to explore the operation mechanism of economic activities in the field of health care as the research task, in order to optimise the allocation of health resources and improve the effectiveness of the use of health resources (Fuchs, 2000; Phelps, 2017). Health economics is a relatively new subject of applied economics that arose from the application of neoclassical economics to the health care industry (Ensor & Witter, 2001). In certain nations, health economics has offered empirical and theoretical support for the creation of applicable public health policies, as well as unmatched advantages in resource allocation (Fuchs, 2000). Health economics encompasses research on the pharmaceutical industry in general, research on the impact of health on the labour market of olders (Bound et al., 1999), And in 2009 there was research on the indirect effects of children and health status on the adult labor market (Smith & statistics, 2009), research on the relationship between health and education (Hunt-McCool & Bishop, 1998) (Grossman, 2017), and research on the impact of lifestyle and environment on health (Farrell & Fuchs, 1982; Mitchell & Popham, 2008; Vrijheid, 2014), Studies have shown that a better living environment is conducive to better health (Carp, 1977). There are also scholars who focus on the economics of mental health. They believe that mental health economics is more like health economics (Culyer et al., 2000). Overseas, study in this field began in the 1960s and 1970s and has grown in sophistication. Arrow published "Uncertainty and the Welfare Economics of Health Care" in 1965 (Arrow, 1965), which was a pioneering application of economic thinking to the study of health care markets, highlighting the fact that uncertainty on both the supply and demand sides of health care services is a distinguishing feature of the health industry. Uncertainty is a distinguishing aspect of the health care sector on both the provider and demand sides. This essay has had a significant influence on academia, policymaking, and the health business, and is recognised as a pioneering work in the genesis and development of health economics, heralding the birth of health economics as a distinct subject. The article in question is regarded as being the first in the field of health economics. Among the fundamental ideas he proposed were risk aversion, moral hazard, information asymmetry, and the externalities of altruistic activity. The foundation of the health economics analytical framework was laid by Michael Grossman's 1972 article, "An Idea of Health Capital and Health Demand" (Grossman, 1972). A significant turning point in the history of health economics is the 1993 publication "Health Economics" by Paul J. Feldstein. With a focus on the systematic study of health care economics to increase the equity and efficacy of health care coverage and by offering an analytical approach to the study of health care services, the author of this work uses numerous examples to demonstrate the importance of economic theory for health care policy. Grossman considers health as a durable capital good that can increase consumer satisfaction, proposes that the demand for health care is a derived demand, successfully incorporates the household production function into the analysis of the utility function of health, and establishes the first health capital demand model. Finally, Mushkin (Mushkin, 1962) defined health in terms of economics. He initially identified education and health as twin ideas in the context of human capital in "Health as an Investment," and then highlighted three characteristics that cause losses to human capital and labour productivity, namely death, disability, and debility. debility), explicitly identifying health as a "component of human capital" and introducing the concept, reasoning, and technique of economics to the study of health concerns. After the issue of health was incorporated into the economic analysis framework of "demand-supply-market structure-equilibrium", oligopoly market theory (oligopoly, pricing, market segmentation), game theory (pure strategic equilibrium, mixed game, extended type (pure strategic equilibrium, mixed game, extended game), public goods theory (public goods, tax system design, voting, externalities), uncertainty economics (risk, insurance, investment), information economics (asymmetric information, adverse selection, signalling), incentive theory (principal-agent theory, contract theory), law and economics (institutional economics, analysis of the nature of the firm, law), etc. can be used to The study of human health is of great significance for the origin and development of health economics.

III. METHODOLOGY

A. Level of health care coverage and GDP

The total cost of health is the monetary representation of the living and physical labour spent by the entire society to provide health care services in a certain nation or area over a specific time period (typically one year). It depicts the transfer of health money from the perspective of the entire society and illustrates the magnitude and structure of government, societal, and individual health investment under various socioeconomic situations. The broad level of health care coverage we measure—the ratio of total health care spending to gross domestic product (GDP), the findings of the broad level of health care mapping the importance society attaches to human health—is a necessary tool to examine the connection between health and the national economy and social health

needs, as well as to assess the reasonableness and equity of the social and economic advantages of various health economic policies. The macroscopic view of the 21-year data in Table 1 shows that Malaysia's health expenditure as a share of GDP is fluctuating upwards, with a significant increase in expenditure from 2.51% in 2020 to 4.12% in 2020. The World Health Organisation has placed Malaysia's healthcare system as the 49th best in the world. Additionally, Malaysia has created initiatives for patients from rural areas and those with low incomes and continues to invest in raising quality of treatment. Thanks to their efforts, Malaysia's healthcare system is swiftly rising to the top of Asia's healthcare systems. For instance, during the past 25 years, newborn mortality rates have considerably decreased.

Table 1. Level of health care coverage and GDP

Years	Current health expenditure (% of GDP) - Malaysia
2000	2.51
2001	2.68
2002	2.67
2003	2.92
2004	2.86
2005	2.79
2006	3.11
2007	3.07
2008	3.01
2009	3.26
2010	3.16
2011	3.31
2012	3.46
2013	3.51
2014	3.71
2015	3.82
2016	3.70
2017	3.71
2018	3.76
2019	3.84
2020	4.12

Source: The World Bank.

B. International comparison of health insurance levels

The academic community unanimously adopted the indicator of total expenditure on health services to examine the moderate medical security level of each country because the medical security systems in each country differ and the basic medical security level varies greatly. The broad medical security level indicator is more comparable than the basic medical security level indicator, so the concept of broad medical security level is also used as the basis of comparison. The idea of comprehensive health care level also serves as the foundation for comparison analysis in this part. The level of medical security depends on both the investment in medical and health care as well as the efficient use of those resources, which ultimately manifests itself in the improvement of the health level. In general, the level of health improves with an increase in medical and health care investment. The improvement in health level is connected to the efficiency of using health resources brought about by its unique policies, and under the same health care investment, the effect of utilising health care resources under different institutional structures is inconsistent.

The basic medical security level varies widely between nations due to their diverse medical security systems, and the academic community has agreed to use the indicator of total health care spending to assess the moderate medical security level in each nation. The notion of wide medical security level is also employed as the basis for comparative analysis in this part since it is more similar than the basic medical security level indicator. In general, the level of health improves as medical and health care expenditures rise, and the degree of medical security is influenced by both these factors as well as the extent to which medical and health care resources are utilised effectively. Finally, this demonstrates that as the economy has grown, so too has the level of health, and that consequently, health spending needs to rise steadily. The medical security level is developing at a little higher rate than the economy, thus it should be modified to coincide with economic growth. According to the statistics gathered in Table 2, developed nations like the United

States, Australia, and France have greater medical spending to GDP ratios than other nations do, with high-income nations having an average ratio of 14.02%. 3.05 percent is the average share in South Asia, which includes Malaysia and Indonesia. Malaysia's share is greater than the average. Regarding the three main health metrics of average life expectancy, newborn and child mortality, and maternal mortality, Malaysia has outperformed the global norm in terms of health outcomes while investing less on health than the global average.

Table 2. International comparison of health insurance levels

Country	Most Recent Year	Most Recent Value
Malaysia	2020	4.12
Australia	2020	10.65
Thailand	2020	4.36
United States	2020	18.82
Singapore	2020	6.05
China	2020	5.59
France	2020	12.21
India	2020	2.96
Indonesia	2020	3.41
Vietnam	2020	4.68

Source: The World Bank.

V. CONCLUSIONS AND POLICY RECOMMENDATIONS

The amount of health care coverage has increased because the demand for medical services has grown faster than the rate at which that coverage has grown as the economy has expanded. Even while Malaysia's spending on healthcare is rising year, it still lags wealthy nations. A key component of health care coverage reform will be determining how to provide a sufficient level of healthcare coverage and allocate scarce resources to wise investments. We are motivated by the preceding health economics research because we think that determining a reasonable level of medical coverage should be in line with Malaysia's economic development and the means of various parties. In other words, the following standards ought to be followed: According to the demand for healthcare, a country's population should experience improved health if it has a sufficient degree of health care coverage. The demand for a variety of medical services increases, and this need is essentially a derived demand for health, as the population expands, the population ages, the illness spectrum evolves, and the public's knowledge of health issues rises. The right degree of medical security should be in line with the level of economic growth from the perspective of medical supply. In order to guarantee that people's fundamental health care requirements are satisfied without going overboard with the limited resources available, we shouldn't set the level of health care coverage too high at the current stage of economic growth in Malaysia. With Malaysia's rising production, we may pick the ideal moment and point of entry to progressively raise the amount of medical insurance The moderate level of medical coverage is based on the effective utilisation of medical resources from the perspective of the usage of medical costs. According to Western economic theory, economic scarcity is the core cause of all societal economic issues, and at a certain stage of economic growth, the issue of how to allocate scarce resources equitably arises as a result. Investment in the medical industry should be properly assessed for its rate of return on investment, just like investment in other areas of the national economy. The secret to guaranteeing the effective use of medical resources is a high rate of return on investment.

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