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# Rising Medical Premiums: Can It Be Cured?

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The recent issue of medical insurance premiums rising by 40–70% has taken Malaysia by storm. Public outrage has been echoed across news outlets, in Parliamentary settings and on social media platforms[1]. This was followed by both insurance and private hospital associations denying that the premium hikes were unjustified[2].

Prime Minister Datuk Seri Anwar Ibrahim has stated that relieving the burden of exorbitant premiums is a priority for the government[3]. Bank Negara Malaysia (BNM), alongside the Ministry of Health (MOH), has been called on to spearhead efforts to provide both interim and long-term solutions[4].

**Views** are short opinion pieces by the author(s) to encourage the exchange of ideas on current issues. They may not necessarily represent the official views of KRI. All errors remain the authors' own.

This view was prepared by Ilyana Mukhriz, a researcher from the Khazanah Research Institute (KRI). The contents are an elaboration of the author's comments in an interview with New Straits Times on 29 November 2024. The author is grateful for the valuable comments from Nik Syafiah Anis Nik Sharifulden.

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[1] Utusan Malaysia (2024); New Straits Times (2024a); MalaysiaNow (2024); Bernama (2024); The Edge (2024a)
[2] The Malaysian Reserve (2024); New Straits Times (2024b)
[3] Malay Mail (2024a)
[4] *The Star* (2024); Malay Mail (2024b)

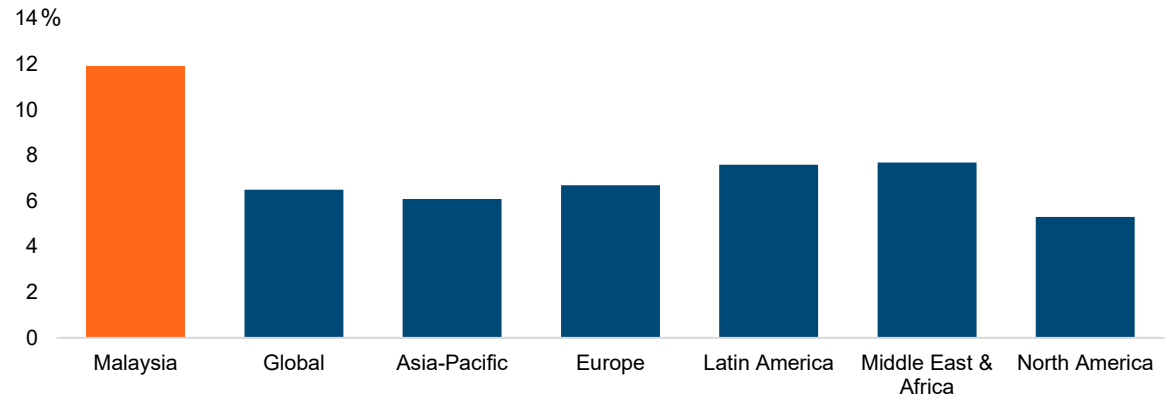
Is this rise in medical insurance premiums unexpected? This article briefly discusses the key factors contributing to the rise and some potential interventions that could be implemented to protect the larger Malaysian population.

## What Drives Medical Costs Up?

The rise in medical insurance premiums is driven mainly by cost pressures due to medical inflation. Medical inflation refers to the increase in cost for healthcare products and services that occurs over time[5]. The increased cost is then transferred on to the patient as the consumer. This phenomenon of medical inflation is not specific to Malaysia, with countries across the globe also struggling with the challenge of rising healthcare costs outpacing wage growth and broader inflation[6].

However, Malaysia's medical inflation rate of 11.9% has been reported to be higher than both the global and Asia Pacific average in 2024[7] (Figure 1). As a comparison, countries such as Indonesia, Singapore and Thailand reported a medical inflation rate of 10.1%, 9.5% and 7.1% respectively. Malaysia's medical inflation rate is expected to rise to 12.6% in 2025, alongside a global rate of 7.2%[8].

**Figure 1: Medical inflation rates, 2024**




Source: AON (2024)

## Population Ageing

There are several factors that contribute towards medical inflation, both in Malaysia and globally. One important factor is population ageing, with Malaysia expected to become an aged society[9] by 2045[10]. Although the country has made great strides in improving life expectancy, we have not been successful in ensuring that the years gained are spent in good health.

[5] Prudential (n.d.)
[6] CBS News (2024); Charlesworth (2014)
[7] AON Global (2024); BNM (2019)
[8] AON Global (2024)
[9] An aged society is when more than 14% of the population is aged 65 years and above (OECD and WHO, 2022)
[10] World Bank (2020)

For example, for Malaysians between the ages of 60 to 64, 25.2% of their life expectancy is likely spent in poor health whereas for those aged between 80 to 84, this amounts to 35.0%. These additional years spent in poor health is associated with higher total health spending due to higher demand for healthcare, particularly for non-communicable diseases (NCDs) such as cancers and cardiovascular diseases. Similarly, countries such as Thailand and Singapore which already have aged societies also have medical inflation rates that were higher than the global average in 2024 at 7.1% and 9.5% respectively[11,12].

## Advancements in Medical Technology

Another major factor driving medical costs up is advancements in medical technology. These advancements include new drugs, devices or services and the provision of treatments for conditions that previously could not be treated. In such cases, new financial costs are incurred where little to no costs were incurred before (e.g. retroviral therapy for the treatment of HIV/AIDS) or where wider patient populations can benefit (e.g. vaccines for new diseases such as Covid-19).

Regardless, it is likely inevitable that healthcare costs continue to rise in the foreseeable future as the demand for healthcare, and arguably better healthcare, increases over time. It could also be argued that these medical advancements may become cheaper over the years, however a lot of the cost still has to be borne in the early years, and Malaysia also relies on the strength of the ringgit when it comes to importing technology. In 2020, Malaysia imported more than USD 1.3 billion worth of medical devices, with 17% of devices procured from companies based in the United States (US)[13].

## Is Buffet Table Syndrome Really A Culprit?

A driver that has often been cited in Malaysia has also been the "buffet syndrome" which refers to overconsumption of medical treatments and medications by individuals with zero co-payment or full rider insurance policies in an attempt to maximise their policy coverage[14]. This overconsumption has been posited as a major contributor towards increased healthcare costs and thus medical inflation[15]. The buffet syndrome has been used to justify the introduction of more co-payment type insurance products earlier in 2024[16].

However, it appears that there is no robust data proving this syndrome to be occurring at a large scale in Malaysia. The assumption that many people want to be hospitalised or would like to receive treatments for no reason seems to be at odds with reality and it is unlikely that a large proportion of the population wants to get a chronic illness simply to benefit from their coverage.

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[11] It is important to note that other factors including healthcare delivery and financing models as well as population size also influence the rate at which medical costs increase.
[12] Krungsri Research (2024); Singapore Department of Statistics (2023); AON Global (2024)
[13] International Trade Administration, US Department of Commerce (n.d.)
[14] BNM (2019); CodeBlue (2024a)
[15] BNM (2019)
[16] Parliament of Malaysia (2024)

Thus, these claims that buffet table syndrome drives medical inflation in Malaysia should be carefully explored before implementing blanket policy interventions that do not necessarily target over-consumption in the healthcare sector.

## A Cross-Agency Approach Needed to Keep Medical Insurance Affordable…

BNM has played an active role, particularly in 2024, in regulating the insurance and takaful industry. Examples of this include the launch of a licensing and regulatory framework for digital insurance and takaful operators (ITOs) as well as their calls for ITOs to address existing protection gaps[17].

These efforts should continue and more can be done to enhance the regulation of ITOs by BNM but tackling the issue of medical insurance hikes and medical inflation in general goes beyond the purview of BNM alone and requires action from other agencies as well. This section will elaborate a few areas that could be improved, although more Malaysia-specific and data-driven research is needed on this topic.

Firstly, transparency of premium increases, if they need to occur, should be enhanced. This should occur alongside the provision of alternative options for the policyholder to prevent termination of their policy. In Australia, insurance providers are required to notify the policyholder in writing if their premium has increased and if the increase is higher than average, the provider must demonstrate to the policyholder that the rise is necessary to cover the benefits offered by their policy. Australia has also taken this one step further by mandating that health insurers obtain approval from the Commonwealth Minister of Health before applying a rate increase. If they are unable to justify that an increase is necessary to meet their obligations to pay benefits, the premium should remain as-is[18].

Secondly, with the issue of overbilling and overconsumption of medical services being cited as a driver for medical inflation and thus premium increases, perhaps it is time to enhance the way insurance providers pay healthcare providers. This involves a shift away from the current model of fee-for-service (FFS) to a value-based model where doctors are rewarded based on patient outcomes.

It has been pointed out in Parliament before that hospital bills for those covered by insurance can be vastly more expensive and the itemised nature of FFS does open up a lot of room for overcharging[19]. In the US it was found that patients who had private insurance were charged 10.7% higher than those without private insurance[20]. An example of a value-based model includes the diagnosis-related groups (DRG) payment system that was recently touted by the Health Minister, Dr Dzulkefly Ahmad, which involves paying a set amount for a patient's treatment[21]. This could help in curbing unnecessary healthcare utilisation and expenditure.

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[17] BNM (2024a); Sinar Daily (2024)
[18] Commonwealth Ombudsman (2023)
[19] Ikegami (2015); CodeBlue (2024b)
[20] Woodworth, Romano, and Holmes (2017)
[21] The Edge (2024b)

Thirdly, there is a need to utilise technology and data in the ITO industry. In order to effectively curb issues such as buffet table syndrome as well as waste, fraud and abuse that is often cited as a main driver for medical inflation, there is a need for robust data to prove this. We rarely see data to evidence these phenomena occurring in the Malaysian population specifically and if we are going to take a blanket approach to curbing these issues, we should have the evidence to prove their existence. The data could also help insurers more accurately price their co-payments or deductibles. This year, BNM has mandated the establishment of an industrywide claims database for better claims analysis and to identify fraud and abuse, which is a good step[22].

Fourth, we should not be quick to put the burden and the blame on the patients and public when it comes to rising healthcare costs. There is a need for enhanced education and awareness programmes to first improve public understanding of how health insurance works. It is possible that not many people understand that irrational and irresponsible healthcare consumption behaviours may lead to higher premiums in the future. In most cases, the public would not have knowledge of whether their symptoms are serious or not which makes it a potential cause of worry and stress, for example when it comes to their children who cannot express the level of pain they are experiencing.

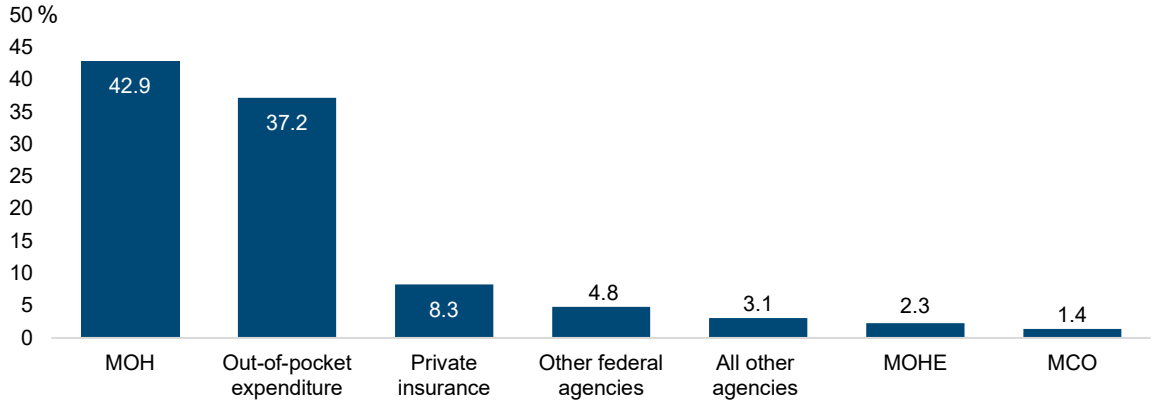
Finally, to effectively control healthcare costs, it is important to have healthcare provider transparency that allows individuals to make better healthcare decisions. This could be transparency from doctors in explaining the reasons treatments are carried out or withheld to the patient. It could also be transparency from the hospitals or clinics themselves whereby healthcare providers share data on costs of procedures that are currently not often disclosed upfront. The publication of these costs on an easily accessible public website could allow patients to more effectively choose the providers that they receive care from. Singapore's MOH publishes hospital bill sizes to allow patients to compare costs between hospitals and this has been reported to spur improvements such as reduction in LASIK prices by more than SGD 1,000[23].

## … But Continued Investment in Public Healthcare Provision is Vital

It is important to note that although the hike in medical premiums is burdensome, medical insurance is not the main source of health expenditure in Malaysia. In 2022, medical insurance made up only 8.3% of total expenditure on health (THE) (Figure 2 on the following page)[24].

[22] BNM (2024b)
[23] Hruza (2020); Health Hub Singapore (2018)
[24] MOH (2024)

**Figure 2: THE by sources of financing in Malaysia, 2022**




Abbreviations: Ministry of Higher Education (MOHE), managed care organisations (MCO)
Note: All other agencies includes the Social Security Organization (SOCSO), Ministry of Defence (MOD) and the Employees Provident Fund (EPF), among others.
Source: MOH (2024)

When looking across income groups , only 13.3% of those in the bottom 40% of households (B40) owned private health insurance in 2019. In comparison, 32.1% of those in the middle 40% of households (M40) and 49.9% of those in the top income group (T20) had private health insurance[25]. Thus, the rise in medical insurance premiums could be seen to impact the M40 most severely since they are more reliant on private insurance than the B40. The M40 households would also be at a disadvantage as a "missing middle" group that do not typically receive monetary aid or qualify for neither social security nets nor tax cuts.

However, in Malaysia we have an existing tax-funded public healthcare system that serves as the largest possible financial pooling mechanism. In past Khazanah Research Institute publications, we have also shown that the preference for public healthcare facilities follows a clear income gradient for outpatient care but for inpatient care there is an increasing preference for public healthcare services even among the top household income groups[26].

Thus, in order to ensure the gap in access to healthcare services is not widened, we should focus on strengthening what has been considered one of our most fundamental assets. This includes allocating more funds to upgrade and enhance existing facilities, modernising our care delivery models through mechanisms such as strategic purchasing and digitalisation as well as ensuring the wellbeing of our healthcare workforce.

## Conclusion

The impending rise in healthcare costs is partially a result of our past successes in extending the longevity of our population and the expansion of healthcare throughout our nation. In light of the burden it has posed on the Malaysian people, the government is currently working towards both short-term and long-term solutions to help keep medical insurance affordable for all. However, it is important to consider that our highly subsidised public healthcare system has been crucial in

[25] MOH (2020)
[26] KRI (2020)

our success in providing universal health coverage. Therefore, it is important that we continue to strengthen our commitment towards public financing of healthcare that focuses on the entire population, rather than groups of contributing individuals. Private health insurance should be a supplementary and complementary financing mechanism that helps optimise how the public healthcare system serves the nation.

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