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DEVELOPING OF MICRO HEALTH TAKAFUL OF AFFORDABLE MONTHLY PAYMENT FOR POOR COMMUNITY IN MALAYSIA

Fauzilah Salleh[1]
Puspa Liza Binti Ghazali[2+]
Ahmad Syukri Yazid[3]
Wan Norhayate Wan Daud[4]
Roslida Abdul Razak[5]

[1,2,3,4,5]*Faculty of Economic and Management Sciences, Universiti Sultan Zainal Abidin, 21300 Kuala Nerus, Terengganu, Malaysia*
[+]*Email: puspaliza21@gmail.com*

(+ Corresponding author)

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ABSTRACT

When people purchase for health and medical takaful plan, they need to commit with the premium contribution as a tabarru' donation to the takaful plan. The study aims to propose the micro medical and health Takaful framework for poor or lower income which is according to expert opinions. According to the method, participants involvement in the focus group discussion are 10 participants to show a greater potential in discussing but lead by a moderator who followed the predesigned script and the session was in parallel with audio or video recording as evidence. The result from the focus group discussion among expertise which the affordable monthly payment for health microtakaful among the poor community is RM20 for outside patient with the total per family is RM30,000 per year (30X) is equal to RM0.667 per RM1, 000 unit. Medical treatment can be made in a government hospital or private hospital/clinic, but the limit expenses are RM30,000. The product can offer 3 packages that the monthly payment for RM5 to RM15 for outside patient per family with differences range of expenses in the microtakaful for medical and health is the best product for poor community income, if it can be implemented in Malaysia as soon as possible.

Contribution/ Originality: Existing literature are normally products which are very expensive and not affordable to the poor or poverty people. By using the method of focus group expertise, they focus the affordable payment per month for the microtakaful product. The study found a new formula of expenses and this will use for affordable people in future.

1. INTRODUCTION

Malaysian Health Care Expenditure increases on the average of 12%-13% per annum and by 2025 could exceed MYR20 billion. The government had allocated a higher budget amounting to MYR23.3 billion in 2015 to provide free or almost free hospital and clinic services to the civilian population. However, these government hospitals and clinics are unable to accommodate the needs of all the population due to the lack of personnel, medicine and supplies, causing many people including the poor forced to seek treatment from private health centers.

The year 2014 recorded a high number of admissions and outpatient attendances in 141 government hospitals of 86,237,051 compared to 5,083,596 in 214 private hospitals. It showed that many people could not afford to go to private hospitals due to the payment of out-of-pocket for personal care burdening them. The alternative way is to

buy health insurance, but the existing health insurance is expensive especially for poor people in Malaysia. These poor people will not contribute to the health insurance scheme even to prevent future hospital costs. Therefore, this research will contribute to the development of an affordable medical and health Takaful framework to be applied by the poor community and give them prompt access to medical and health services.

The research will adopt both quantitative via survey and qualitative via focus group discussion. A framework will be developed to assess the health aspects of such diseases, cost of medicine and surgery that are affordable for poor people. This study is based on data of Takaful operators, Department of Social Welfare, Ministry of Health, Office of Religious Affairs (Zakat Division) and National Bank. Their views and cooperation are essential for the implementation of health Takaful scheme indirectly contributing to implementing the government's program which focused on the hard core poor, poor, and low (B40) and moderate income earners (M40).

As takaful plan have a comparable function to the conventional insurance, which to protect their members from any catastrophes, takaful becomes an alternative protection plan to the Muslim people as its counterpart has contradicted with the Islamic rulings (Htay *et al*., 2015). Medical and health insurance or takaful related plan is important to have for any income level.

2. LITERATURE REVIEW

In 1999, Central bank of Malaysia had identified that MHI/MHT business as the emerging trend and an important sector of insurance and takaful industry for the future based on facts that ageing population requiring high medical costs; Malaysians aged 55 and above are expected to increase; improvement in mortality for both males and females; currently, 70 and 75, respectively, to increase to 75 and 79, respectively, in the year 2020; breakdown of extended family structure; caring family values expected and advocated by the government, for the old-aged parents may possibly change in the near future; healthcare as an employment benefit is fast becoming the incentive offered by employers to ensure employee loyalty and retention; and personal income tax exemption (Abdul and Mohd, 2010). Prior in 1970s, major industry players of Medical and health insurance (MHI) in Malaysia being foreign-based insurers such as American International Assurance, AETNA, and Prudential to name a few.

The above scenarios resulted in 1999, the first national health insurance scheme was born known as SIHAT Malaysia, with several local insurance companies subscribing to the scheme. SIHAT Malaysia is a new hospital and surgical insurance policy incorporating a range of hospitalization plans catering to a wide segment of society (Abdul and Mohd, 2010). As for MHT, Central Bank of Malaysia indicate that data collection and performance reporting on MHTonly started in 2003, after four Takaful operators have been granted licences to operate.

2.1. Healthcare and Poor People

According to Doorslaer and O'Donnell (2008) Medical care of household are expensive and the budget of health care needed to be introduced. Population in a developing country like Malaysia is divided into three classes i.e the rich, middle and poor based on their level of income.

According to Jütting (2003) poor people lack access to health care with a negative impact on their dignity, human capital formation and their risk-management options. The study found that, although the health insurance schemes reached the "poor" in general, the "poorest of the poor" find it financially difficult to participate. To overcome the constraints, the study recommended for well-targeted subsidies (partially), flexibility in payment procedure (instalment), education and strengthening of riks awareness among the poor. Hence, the establishment of a mechanisme that can increase the availability and improve the quality of health care in the developing world is a matter of an ungency (O'Donnell, 2007).

A dual system of the healthcare in Malaysia, which are private and public health services, co-exists in which the serviec of the health care is facilatated in the nation via health clinics and public hospitals across the country (Yu *et al*., 2008). It is recorded that the Malaysian government has provided a subsidy around 98% to the health services

through the Ministry of Health for primary care services at health clinics in government hospitals as well as secondary and tertiary care services (Yu *et al*., 2008).

2.2. Empirical Studies on Medical and Health Insurance

Seemingly, this issue has received a numerous interest by the previous study in Malaysia, in which most of the lower income earners especially poor people have not proper financial protection against financial losses (Noor and Zuriah, 2012). By examinig the respondents comprises of poor people category living in the rural region of Perak, Malaysia, Noor and Zuriah (2012) discovered that about 97% from the total respondents are having no financial protection and even they are incapable of contributing in order to get such protection. Researchers have suggested for the government's in facilitating the financial capacity for those target people to be principally protected for death, medical and savings benefits. The needs of the lower income can be fulfiled through micro-takaful. In Malaysia, the government has giving a subsidy up to 58.2% from the total funds allocated for public health whereas the remaining 41.8% is allocated for the private sector whereby out-of-pocket payments (73.8%) dominated by private finance sources and only a minor component covered by private insurance (13.7%) (Yu *et al*., 2008).

Although insurance covering health risk has been rank as one of the most needed by low-income individuals, in developing countries, the provision of health insurance to low-income individuals is still very limited because of the complexity of delivering healthcare in less developed areas (Yao, 2013). Recently, "microinsurance" products which reflect the efforts of non-profit organisations to find a way to provide insurance in the developing world become renowned. However, sustainability matter is one of the main concerns to be observed. Based on data gathered on a micro health insurance programme in Pakistan, Yao (2013) analysed the trend of sustainability by measuring the development of claim experiences in renewal policies as they are only given only coverage option. The result showed that larger claims households during the policy period are more likely to renew their policy for the next period. Although that pattern is superficially consistent with adverse selection and decreasing sustainability, it was found instead that when compared with first timer households insurance buyer, the renewed households have significantly lower claim frequency and total claim amounts.

Exploratorily studied the importance of health insurance, impediments of health insurance and potential implications of an economic crisis on health and health insurance in India, Venkateshwarlu (2016) found that health insurance directly improves the entrepreneurship and indirectly develops the economy as a whole in India. Constraints like lack of knowledge towards the importance of medical and health insurance among the public, unable to purchase the medical and health insurance plan, limited choice of customers, reluctance to participate for those plans by certain population and having no recognition of health insurance by the government in India were among the main reasons for underdeveloped health insurance in India. Upon that, Triangular Model for Universal Health Insurance was suggested by the resercher to be applied in India.

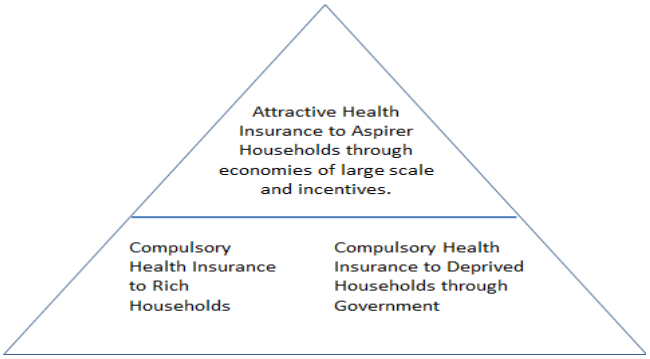

Figure-1. Triangular Model for Universal Health Insurance

Source: Venkateshwarlu (2016)

Micro life insurance is typically one of the most demanded forms of coverage nowadays. As a form of health or life insurance, which offers limited protection at a low contribution for the poor population and designed to help them cover themselves againts insurable risks, micro insurance is seen as one of the major risk managing tools for the poor and low income groups and a potential markets for business (Varshini and Suresh, 2013). However, for some vicinity, for example, study by Forbes (2010) revealed that financial MHI scheme viability is a major problem even though resources have been used to start these schemes in rural India and the new services may fail if not subsidised and the experiment might undermine what was already in place. The concept of micro health insurance can be traced back to the 'Sickness Funds' of some European countries that were formed by workers way back in the 19th century during the industrial revolution and later followed by 'German Social Health Insurance' and 'The Netherlands Social Health Insurance'. In Asia, Jyorei scheme in Japan and the Chinese Rural Cooperative Medical System lead the region (Dror, 2007). In order to to structure the extant knowledge on the determinants of micro-insurance demand, Eling *et al.* (2014) have thourughly reviewed the academic literature on micro- insurance demand published between 2000 and early 2014 and concluded 12 key factors affecting microinsurance demand; Economic factors (Price of insurance, Income and wealth (access to credit/ liquidity)), Social and cultural factors (Risk aversion, Non-performance and basis risk, Trust and peer effects, Religion/fatalism, Financial literacy and education), Structural factors (Informal risk sharing, Quality of service, Risk exposure), Personal and demographic factors (Age, Gender). Demonstrated the importance of examining insurance coverage within households particularly in low and middle income settings, Govender *et al.* (2014) within the context of South Africa, found that private medical scheme membership has a significant positive effect on the demand for private health service economically. The foundational study in Ghana by Akotey *et al.* (2011) for example, has shown that premium flexibility, income level and nodal agency are significant determinants of micro-insurance demand in the country. This indicates that the price of insurance and the target market level of income should be considered as one of the main factors in designing an insurance product regardless of which part of the world (countries). Targeting 75% of penetration rate by 2020, promoting competitive and innovative insurance and takaful sectors remains (Malaysian National Bank, 2015). By using the standard and two-part Poisson models (TPM) in determining the effect of insurance ownership on utilization, Samsudin *et al.* (2016) provide new evidence from an emerging market, Malaysia, where the voluntary purchase of private health insurance co-exists with almost free public health care. Also, insurance ownership was found to be significant in determining access to hospitalization either private or public health care. This study has shown the importance and impact of having health insurace protection which currently has yet fully reached the target groups.

2.3. Micro Health Framework

Bank Negara Malaysia (BNM) defined microtakaful product is a product designed to respond on the financial protection needs of low-income households. In this respect:

a) Financial protection means being able to access timely and adequate financial resources to:
   i. Cope with major expenses
   ii. Financial protection from financial burden arising from unexpected or catastrophe events
b) Low income households refer to poor people, vulnerable or lower middle income households, which is groups that has been previously excluded from access insurance or takaful product.

The framework of MHT/MHI scheme relies on three basic principles which are accessibility, affordability and simplicity of contracts. Figure 2 below shows the application of the scheme:

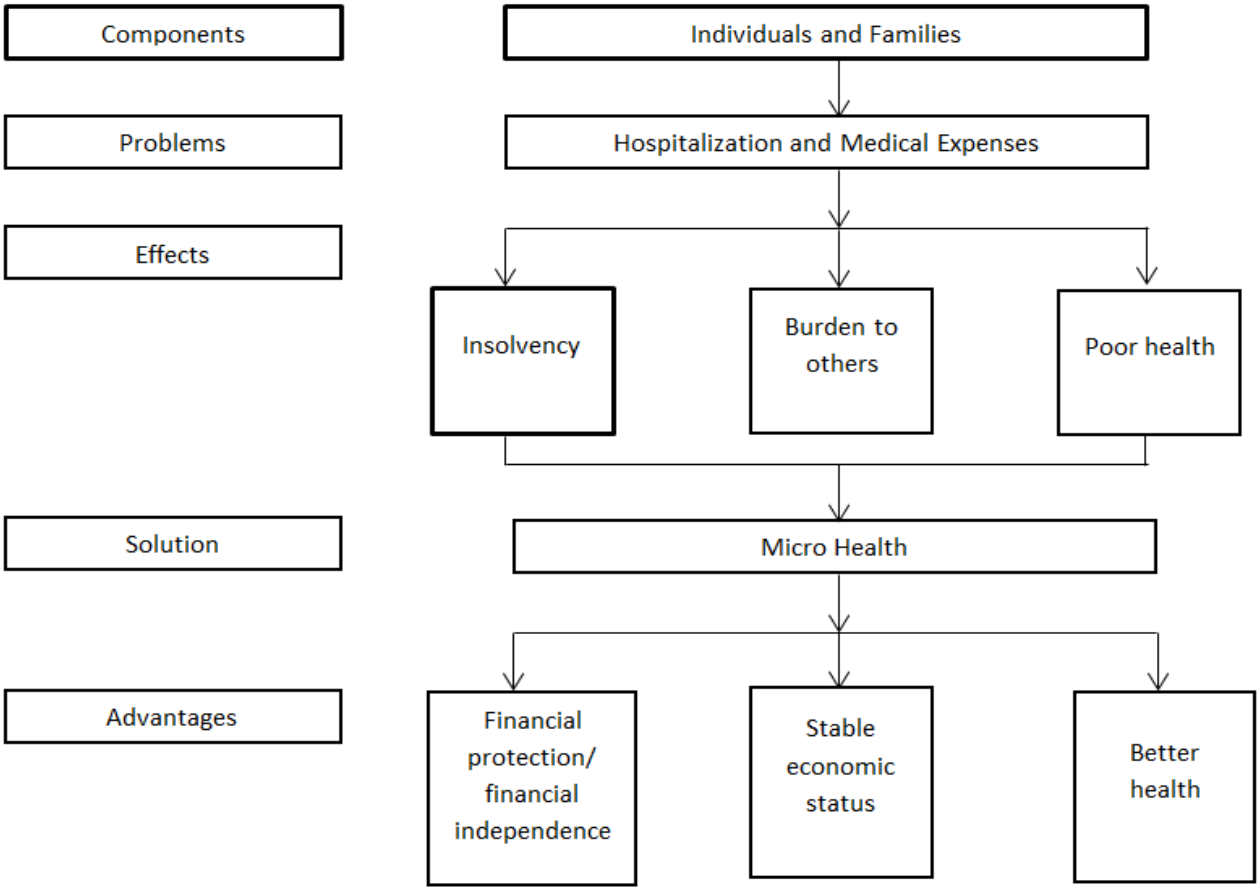

Figure-2. Framework of MHT/MHI Scheme

Source: www.insurance.gov.ph, 2018

3. METHODOLOGY

3.1. Unit of Analysis (UOA)

The unit of analysis is an entity, group or individual that is being scrutinized in a study. In a qualitative approach via Focus Group Discussion (FGD), the UOA are Takaful operator and other related agencies. Takaful operator and related agencies have significant roles in developing the framework for coastal erosion. Therefore, it can be concluded that the UOA being selected gives a commitment in FGD which are as follows:

Table-1. Unit of Analysis involved in FGD

Agencies	No. of Representatives
Takaful Operator	2
Ministry of Health	2
Bank Negara	2
Zakat	2
Academician	2

Source: Yao (2013)

Survey selected among poor community in quantitative approach aids in gathering information of diseases, medical expenses incurred, and capable premium to participate in the policy. The information is essential for the FGD to develop the proper framework.

3.2. Data Collection of the Study

The study utilized a qualitative approach via FGD method. FGD was administered in a group of 10 people in a session, accompanied by five agencies with each agency represented by two persons (see Table 1), led by a

moderator who followed the predesigned script and the session was in parallel with audio or video recording as evidence. The optimum number for the participants' involvement in FGD is between six to eight participants to show a greater potential in discussing such topic, while the number of participants between six and ten are enough to achieve numerous perspectives. Therefore, the study creates a decision to conduct FGD with eight participants as mentioned above. Thus, the audio and video that have been recorded generate a transcription of words called as verbatim. The whole session of FGD normally ends up between one to two hours. FGD is beneficial in producing a lively and proactive discussion and it will generate the required information.

During this meeting, all collaboration agencies were exposed to the data analyzed from quantitative method which involved the data presenting the entitled diseases, medical costs incurred and value of contribution since it is the main topic of discussion. This was followed by a discussion on the suitability of the framework, and the flow in handling the framework of Takaful scheme. FGD also highlighted the issue on risk mitigation of the financial impacts or compensation correlated financial burden in medical costs. It is necessary to notify that micro health Takaful scheme is essential nowadays due to the economic problem nowadays and financial burden posed on the individuals. The Takaful scheme plays a significant role in lessening the burden of financial consequences and it is being used as an initial preparedness phase of an urgent situation.

The crucial parts during the discussion in FGD together with Takaful operator, Ministry of Health, Bank Negara, Zakat and academician are identifying the scheme proposed in this study, providing appropriate scheme for poor community or resident family based on the income level, deciding on compensation ratio, ensuring that comprehensive coverage is involved in the scheme, and proposing the structure of premium that should be paid by the participant. Decision on the type of coverage provided by the insurer/Takaful operator and the structure of premium specified is one of the successful strategies for risk mitigation measure.

3.3. Process of Qualitative Data Analysis

After collecting the data and gathering all the required information via FGD, the next process is data analysis. Data analysis is the process of combining all the data collected and transforming it in the form of explanation or interpretation via ATLAS.ti. The processes of qualitative data analysis are presented in Figure as below:

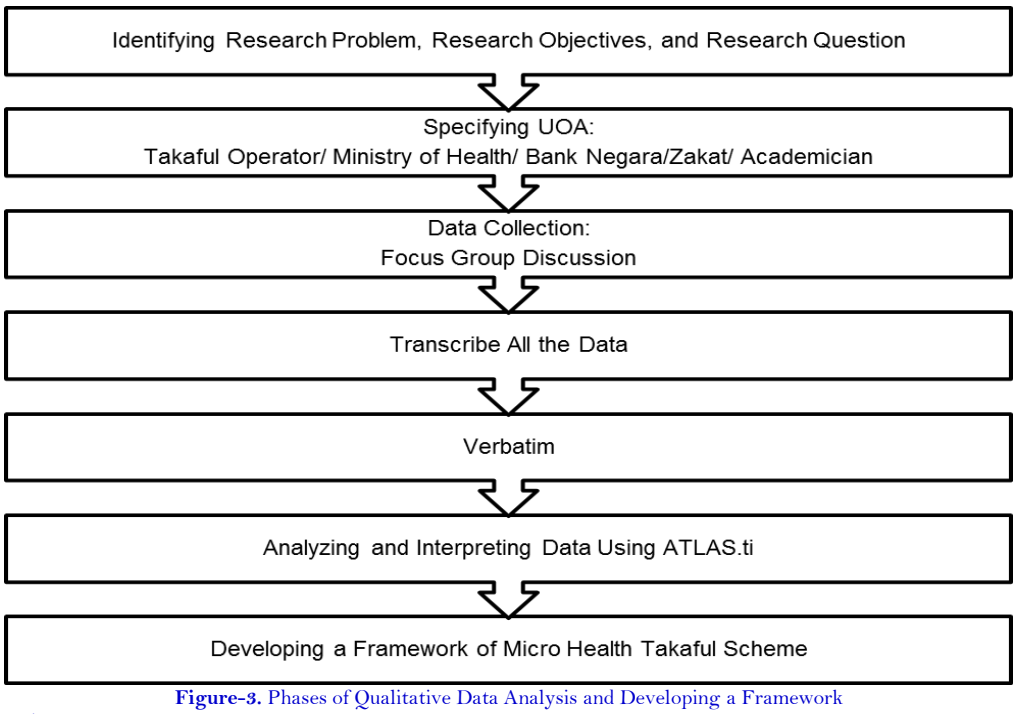

Figure-3. Phases of Qualitative Data Analysis and Developing a Framework

Source: Yao (2013)

4. FINDINGS AND DISCUSSIONS

After focus group discussion (FGD) among expertise such as Takaful Operator, Ministry of Health, Bank Negara Malaysia, Pusat Zakat and Academia, they found the health microtakaful among the poor community is RM0.667 per RM1000 for the whole family. It means that they paid RM20 for claiming RM30,000 per year. They can claim only for outpatient expenses whether in government hospital/clinic or private hospital/clinic. According to Ghazali *et al.* (2011;2012;2015;2016) where the meaning of RM1000 is equal X . Therefore, RM30,000 is equal to 30X as given below.

Partition of expenses per 1000 is RM20 out of RM30, 000 (30X) = 20/30

= RM0.667

4.1. Another Alternatives Package for Health of Micro Takaful

Normally, the takaful operators have given the alternatives in their product and the same thing for this product. Some poor community can pay for RM20 per month but many of them cannot pay for it. It is a good thing to give the poor community a choice in the package which is according to their affordable monthly payment. There are 3 choices in the packages are RM5 per month, RM10 per month and RM15 per month but the value for expenses of outpatient can claim is also different.

a) Types of Micro Health Takaful Package

i. Package RM5 Per Month

If the expertise had decided RM20 for RM30, 000 claims and the value of RM5

= (RM5x RM30, 000)/RM20

= RM7, 500 per year for an outpatient claim

ii. Package RM10 Per Month

If the expertise had decided RM20 for RM30, 000 claims and the value of RM10

= (RM10x RM30, 000)/RM20

= RM15, 000 per year for an outpatient claim

iii. Package RM15 Per Month

If the expertise had decided RM20 for RM30, 000 claims and the value of RM15

= (RM15x RM30, 000)/RM20

= RM22, 500 per year for an outpatient claim

b) Check for Partition per RM1000 is RM0.667 for every package

i. Package RM5 Per Month (Claim RM7, 500 per year)

(RM0.667 x RM7, 500)/RM1000 = RM5.00

ii. Package RM10 Per Month (Claim RM15, 000 per year)

(RM0.667 x RM15, 000)/RM1000 = RM10.00

iii. Package RM15 Per Month (Claim RM22, 500 per year)

(RM0.667 x RM22, 500)/RM1000 = RM15.00

Therefore, according to mathematical calculation, the value of every package is parallel to expertise' guideline in the partition of expenses per 1000 is RM20 out of RM30, 000 is equal to RM0.0667.

5. CONCLUSION

This study was carried out among the poor community who have strongly utilized the services provided by public hospitals or clinic specifically in several locations for each state. Thus, the result might only be generalized to the above population. In other words, the findings might be different if the scope is increased to involve entire

locations in each state of the research location. Furthermore, these characteristics might be significantly different from the characteristics of the poor community in this study.

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