Asean Insurance Pulse 2024

Healthcare financing in ASEAN

An annual market survey

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ASEAN Insurance Pulse 2024

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Foreword Malaysian Re

Dear Readers,

This year´s 8th edition of ASEAN Insurance Pulse is dedicated to the vital topic of healthcare financing. We delve into the diverse healthcare structures and financing mechanisms from across the ASEAN region, identifying how insurers might enhance their involvement in the sector to simultaneously improve the health of our communities and achieve market growth.

As we show in this edition, ASEAN countries each follow their own healthcare structure and financing mechanism/s (often hybrid public-private). Equally, countries face – and apply individual solutions to – specific challenges linked to deteriorating health trends, regional dynamics, economic conditions and governance frameworks. Lack of healthcare access for rural communities, high out-of-pocket expenditure (which totalled USD 46 billion across ASEAN in 2021) and escalating medical costs are common issues.

ASEAN consumers increasingly see the benefits of private health insurance, given factors such as higher risk and insurance awareness (especially after COVID-19), rising disposable incomes and the desire for more comprehensive and higher quality protection. However, despite presenting an attractive alternative to the public system, market expansion is challenged by high costs and affordability. ASEAN government budgets are similarly confronted with increasing healthcare cost burdens, including from healthcare infrastructure investments and negative population health trends. The pressure on governments to provide equitable access to healthcare, whilst balancing cost and quality, remains extremely high.

As for past editions, ASEAN Insurance Pulse 2024 presents a snapshot of the market and the avenues that it chooses to provide protection to society and the economy.

We would like to express our deepest appreciation to the industry leaders who participated in this survey, sharing their valuable perspectives and insights with our researchers at Faber Consulting. We are also extremely grateful to Bank Negara Malaysia, the ASEAN Insurance Council, the General Insurance Association of Malaysia (PIAM), the Life Insurance Association of Malaysia (LIAM), the Malaysian Takaful Association (MTA) and the respective Insurance Associations of ASEAN countries for their steadfast support of this initiative.

We hope that you enjoy reading this edition of Pulse and look forward to your feedback.

Ahmad Noor Azhari Abdul Manaf
President & Chief Executive Officer,
Malaysian Reinsurance Berhad

Foreword Faber Consulting

Dear Readers,

We are pleased to present ASEAN Insurance Pulse 2024. This 8th edition of Pulse focuses on the many and varied challenges associated with healthcare financing across the region, and on how insurers can help to improve health protection and address rising medical costs.

We would like to express our deep gratitude to Malaysian Re for enabling this research. Through its continued support of ASEAN Insurance Pulse, Malaysian Re demonstrates its commitment to advancing ASEAN insurance markets and strengthening the role of insurance.

As in past years, alongside our desktop research, this report also incorporates valuable insights from industry leaders – insights that derive from direct conversations and which add to the depth and substance of the report. We are extremely grateful to the survey participants for their time and for the expertise that they shared so openly with us. It was, as always, fascinating to hear the perspectives of regional experts, and heartening to know that we are all working together towards a brighter and healthier future for the market and ASEAN communities.

We hope that you enjoy reading this edition of ASEAN Insurance Pulse and find its content helpful for your business and the communities that you support.

Henner Alms
Partner,
Faber Consulting

Andreas Bollmann
Partner,
Faber Consulting

Key findings

ASEAN healthcare systems and financing vary widely, shaped by socio-political and economic contexts: e.g. Brunei and Thailand provide tax-funded universal healthcare coverage; Indonesia and the Philippines have national health insurance schemes based on contributions from workers and employers; private health insurance (estimated at USD 7.5 billion in 2023) – plays a significant role in wealthier urban populations; while out-of-pocket expenditure dominates in Myanmar and Cambodia (respectively 70 % and 55 % in 2021).

Demand for private health insurance in ASEAN countries is rising due to factors including higher disposable incomes and literacy rates, increasing internet access, improved access to healthcare and increasing awareness of the value of insurance – including from COVID-19, which prompted individuals to adopt healthier lifestyles and reassess their health insurance coverage. In addition, in most ASEAN countries the private healthcare system is perceived as more efficient than the public service.

Most of Pulse 2024's survey participants perceive the healthcare system of their country as satisfactory or partly satisfactory. However, healthcare provision is not equitable – urban areas have less access to healthcare services and wealth substantially impacts the quality of the available treatment. More importantly, the outlook is negative due to rising healthcare costs (including from medical inflation), ageing populations and a growing disease burden, including from chronic diseases such as diabetes, cancer, cardiovascular issues and obesity, exacerbated by unhealthy eating habits and sedentary lifestyles.

Against these cost pressures, public systems are at risk due to their primary funding source (government expenditure) – healthcare quality and accessibility suffer as governments seek to reduce or contain the increasing cost burden.

Private systems similarly face rising costs, including from medical inflation which most participants reported had increased well above general inflation, as well as from opaque costs (lack of correlation between treatment quality and cost) and overconsumption of treatment provision. Participants also highlighted that patient-insurer-provider interests are not aligned, with patients and private hospitals lacking incentives to control costs. Participants described the health line – which is often written as a rider to sell life policies – as «at best marginally profitable». Instances of new capacity entering the market were correspondingly few and far between.

Health insurance rates are correspondingly rising substantially. This can dramatically impact older age groups (compounding the higher rates they already experience from being in a higher risk category) and threatens health insurance affordability and attempts to expand coverage, including to the lower income segments of society. As ASEAN's young populations age and increasingly enter higher age cohorts, the outlook is that insureds could cancel their policies due to lack of affordability. This could reverse any past advances in health insurance penetration.

Other strategies to combat rising claims costs – aside from rate increases – are risk reduction (e.g. exclusions and reduced limits), cost control (e.g. scrutinizing hospital bills and increasing outpatient treatments), pre-emptive measures (e.g. collaborating with certain hospitals and preauthorising elective procedures), and working with policymakers, regulators and hospital operators to improve market conditions, develop standards (e.g. the Diagnosis-Related Group system), improve alignment (e.g. patient co-payment options) and raise awareness amongst insureds of the need to control costs. Other cost control recommendations from survey participants included investing more in prevention and education to reign in the rapid rise in non-communicable diseases and greater use of digital technology and telemedicine.

Methodology

The findings of this report are supported by 16 structured interviews with executives representing regional and international re/insurance companies, intermediaries, policymakers and trade associations. The interviews were conducted in August and September 2024 by Faber Consulting, a Zurich-based research, communication and business development consultancy. Interviewees belong to the regional network of Faber Consulting or were recommended by Malaysian Re. In addition, the General Insurance Association of Malaysia (PIAM) encouraged their members to support this research.

We would like to thank the following organisations for sharing their insights with us:

- AIG, Malaysia
- Allianz Ayudhya, Thailand
- Berjaya Sompo Insurance Berhad
- Campu Lonpac Insurance, Cambodia
- General Insurance Association of Malaysia, Malaysia
- Great Eastern General Insurance Berhad, Malaysia
- Life Insurance Association of Malaysia (LIAM)
- Malaysian Re, Malaysia
- National Insurance Company, Brunei
- National Reinsurance Corporation of the Philippines
- Philippines Insurers and Reinsurers Association
- Swiss Re, Malaysia
- Takaful Brunei Darussalam
- Vietnam National Reinsurance Corporation, Vietnam
- Wahana Tata Insurance, Indonesia
- Gallagher Re, Malaysia

Market overview

HEALTHCARE FINANCING

Three approaches to financing healthcare prevail globally

Healthcare systems around the world are shaped by different socio-political and economic contexts, and each aims to provide adequate healthcare services to its population. Although their structures and financing mechanisms differ, these systems generally seek to achieve the universal goals of equity, quality and financial protection in healthcare. Broadly speaking, three main approaches to healthcare financing dominate international discussions: the Beveridge model, the Bismarck model and private health insurance systems.

The Beveridge model: A strong role for government with a focus on universal access to care

Named after Sir William Beveridge, the Beveridge model forms the basis of many publicly funded healthcare systems. The UK's National Health Service (NHS) is the quintessential example of this model, where healthcare is funded primarily by the government through tax revenues. In this system, the government owns and operates most healthcare providers, from hospitals to clinics, and healthcare is provided free at the point of use to all residents.

A key feature of the Beveridge model is its emphasis on universal access to care. Because it is tax-financed, it eliminates most out-of-pocket costs for patients, reducing financial barriers to healthcare. The government often plays a central role in controlling costs, regulating the prices of treatments, medicines and the salaries of health professionals, while setting standards to ensure the quality of care.

While this model excels at providing universal coverage, its limitations often include long waiting times and budget constraints. Centralised control can also lead to bureaucratic inefficiencies that can affect the timeliness and quality of healthcare.

The Bismarck model: Compulsory social insurance financed by employers and employees

The Bismarck Model, named after German Chancellor Otto von Bismarck, who pioneered social health insurance systems, is based on a system of mandatory health insurance funded through employer and employee contributions. Unlike the Beveridge system, which is state-run, the Bismarck model relies on non-profit «sickness funds» or insurance companies that are tightly regulated by the government. This ensures that healthcare services are accessible and affordable, while maintaining a pluralistic provider network.

In the Bismarck model, healthcare providers, such as doctors and hospitals, tend to be privately owned. The system offers broad access to healthcare services, ensuring that most people are covered. Because insurance contributions are proportionate to income, the system inherently redistributes wealth, ensuring equity in healthcare access.

However, managing costs in a Bismarck system can be complex, especially when healthcare demands rise with an aging population or increasing medical innovations. There is also an ongoing challenge of regulating private insurers and maintaining fairness in contribution levels, without eroding financial sustainability.

Private health insurance model: A market-based model that creates a competitive environment

In contrast to the Beveridge and Bismarck models, a private health insurance system is primarily market-based, with individuals purchasing health insurance directly from private insurers. This model is prevalent in countries such as the US, where access to healthcare is often linked to employment or the ability to purchase insurance independently. The private insurance model tends to create a competitive market for healthcare services, which can drive innovation and improve the quality of services.

However, this system often results in significant inequalities in access to healthcare, as coverage is highly dependent on a person's financial status. Those without adequate employment or income often go without essential healthcare services or face financial ruin due to high medical bills. In addition, administrative costs are typically higher in private insurance systems due to the complexity of managing multiple insurers and the fragmentation of services.

Balancing cost control with adequate coverage is a major challenge in private insurance-based systems. High premiums, deductibles and out-of-pocket expenses can prevent equitable access to healthcare services, often leaving vulnerable populations underinsured or uninsured.

Healthcare systems and financing in ASEAN

In the ASEAN region, healthcare systems and financing mechanisms vary widely, reflecting a mixture of the abovementioned models. Countries like Brunei and Thailand have developed healthcare systems inspired by the Beveridge model, with universal health coverage funded through taxes. In contrast, others, such as Singapore, have adopted hybrid models, combining elements of state oversight with private-sector involvement and compulsory savings schemes.

Meanwhile, countries like Indonesia and the Philippines have shifted towards more inclusive healthcare systems by implementing national health insurance schemes inspired by the Bismarck model. These systems rely on contributions from workers and employers, though challenges remain in achieving full population coverage and addressing disparities in healthcare quality between urban and rural areas.

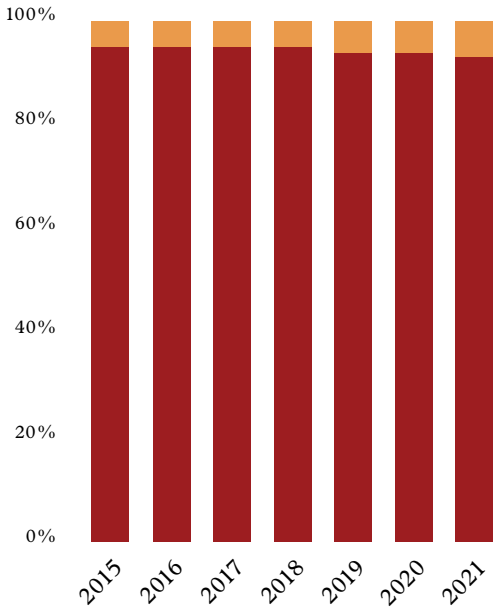
Private insurance also plays a significant role in many ASEAN countries, particularly in wealthier urban populations or expatriate communities. However, the over-reliance on private health insurance may widen the gap in healthcare access between high- and low-income groups, a common concern across the region.

As ASEAN countries move toward broader healthcare reforms, they face the challenge of combining the strengths of these different models — ensuring universal access while balancing costs, quality and equity. The exploration of ASEAN healthcare systems and financing mechanisms detailed in the subsequent pages of this report, will highlight how regional dynamics, economic conditions and governance frameworks shape the healthcare landscape, and how countries can optimise healthcare financing to achieve sustainable, inclusive and high-quality healthcare for all.

Brunei Darussalam

Brunei's healthcare system is predominantly government-funded and provides comprehensive, high-quality services to its small population of around 440,000. The Ministry of Health oversees the public healthcare sector, which is complemented by private providers. Healthcare is heavily subsidised and citizens enjoy free medical services, including hospital care and specialist treatment. The country faces challenges related to non-communicable diseases (NCDs), which account for a significant proportion of mortality. Brunei's healthcare expenditure is high by regional standards, with a strong focus on preventive healthcare and digital health initiatives to improve efficiency.

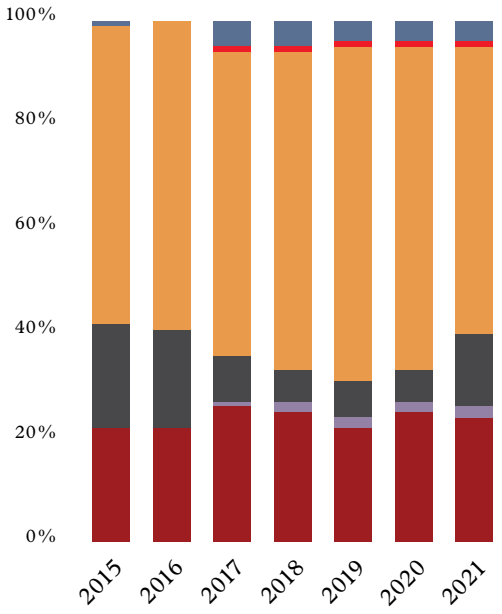
Sources of healthcare financing



Cambodia

Cambodia has a mixed healthcare system, with both the public and private sectors playing important roles. The Ministry of Health leads public healthcare services, but private providers are an important part of urban healthcare services. Challenges include a high prevalence of infectious diseases, underfunded public healthcare services and significant out-of-pocket expenditure. Cambodia's healthcare system faces infrastructure and human resource constraints, particularly in rural areas. The healthcare burden of NCDs is increasing, while public healthcare financing remains low. Despite some improvements, access to quality healthcare remains inequitable, especially for low-income segments.

Sources of healthcare financing



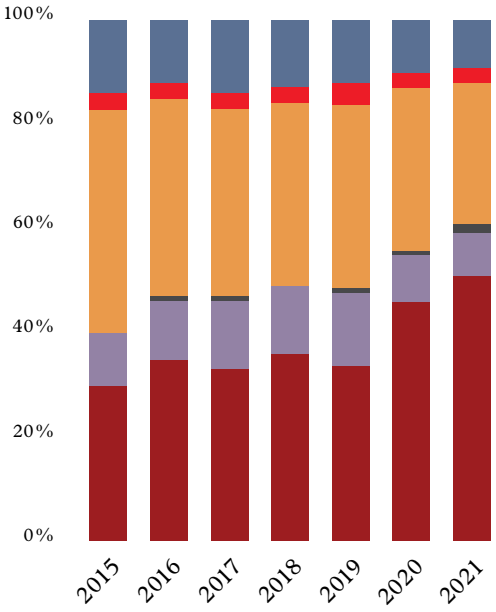
Other
Voluntary prepayments
Out-of-pocket expenses
External aid
Social health insurance contributions
Goverment transfers

Source: Faber Consulting, based on WHO Global Health Expenditure Database

Indonesia

Indonesia has a mixed healthcare system, combining public and private providers in a decentralised structure. The Ministry of Health sets policy, while local governments manage service delivery. The introduction of the Jaminan Kesehatan Nasional (JKN) in 2014 aimed to reduce out-of-pocket spending, but sustainability challenges remain, particularly with rising costs related to NCDs. Improvements in digital infrastructure and better distribution of healthcare workers are essential for equitable healthcare. Despite steady GDP growth, healthcare spending remains low at USD 120 per capita.

Sources of healthcare financing



Other
Voluntary prepayments
Out-of-pocket expenses
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Social health insurance contributions
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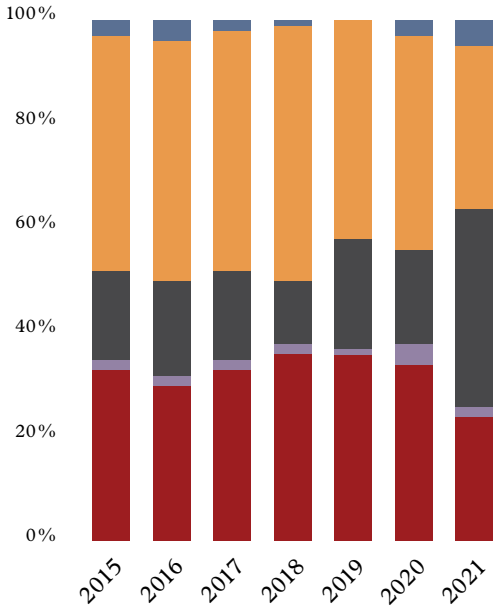
Source: Faber Consulting, based on WHO Global Health Expenditure Database

Lao PDR

Lao PDR's healthcare system is heavily dependent on external aid, with limited public healthcare funding and a growing private healthcare sector. The Ministry of Health manages service delivery through a network of provincial and district hospitals and health centres. The country faces a severe shortage of healthcare workers, particularly in rural areas, which contributes to inequalities in access to care. NCDs are a growing concern, and the government is focusing on expanding primary healthcare services. Public healthcare financing is relatively low and out-of-pocket expenditure remains high, making healthcare less accessible to the poor.

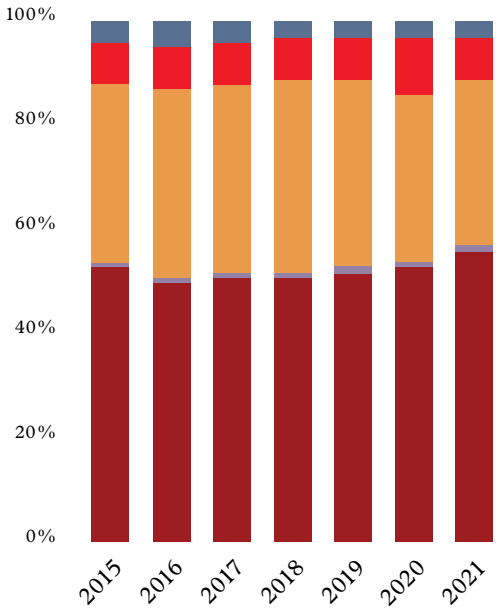
Sources of healthcare financing



Malaysia

Malaysia's healthcare system is a mix of government-funded services and a growing private sector. The Ministry of Health manages public services and undertakes initiatives to grow the share of the private sector. By 2050, 16.8 % of the population is expected to be over 65. The country faces an uneven distribution of resources and services, particularly between urban and rural areas. Investment in infrastructure, especially primary healthcare, is critical. With resilient GDP growth (3.1 % -4.0 %), Malaysia has a relatively high number of healthcare workers, but mental health concerns have emerged among the workforce.

Sources of healthcare financing



Source: Faber Consulting, based on WHO Global Health Expenditure Database

Malaysia's government to reform its health system

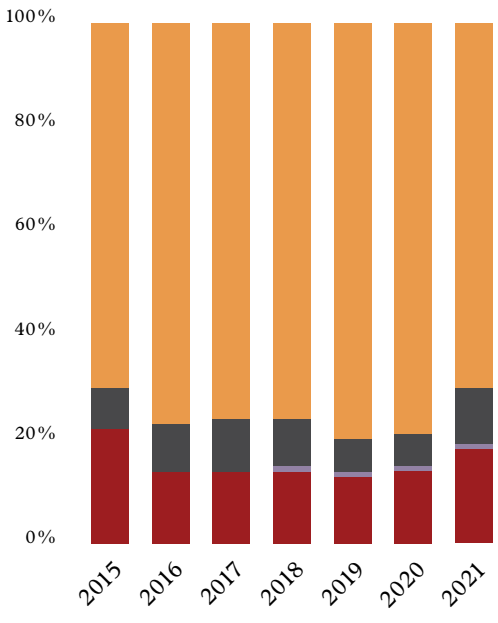
The **2023 Health White Paper for Malaysia**, published by the Ministry of Health, Malaysia, sets out a comprehensive proposal for reforming the Malaysian health system for greater equitability, sustainability and resilience. The Ministry's proposal focuses on four reform pillars:

- Pillar 1 seeks to transform healthcare service delivery by promoting primary healthcare and bringing care closer to communities. Shifting the focus from inpatient treatment to ambulatory care, where possible, will help to reduce the pressure on hospital services. Furthermore, the reform aims to enhance the system's efficiency thorough public-private partnerships, the integration of digital technologies and by implementing new management approaches.
- Pillar 2 focuses on promoting health and disease prevention. Digital health technologies will be prioritised to improve data collection, strengthening the country's health emergency preparedness. The introduction of incentives and disincentives will help to acculturate healthy behaviours.
- Pillar 3 aims to ensure comprehensive, affordable services for all, including by increasing health funding to up to 5 % of GDP, from sources such as the Government, individuals and corporates. The proposal also sets out adjusting fee structures to income, introducing a benefit package financed by a dedicated health fund and strengthening the role of the strategic purchaser.
- Pillar 4 focuses on strengthening the system's foundation and governance, including by improving health-related policies, legislation and regulation, by fortifying the healthcare workforce, and by stimulating research, innovation and evidence-based approaches.

Myanmar

Myanmar's healthcare system is a mix of public and private sectors, with the government providing basic healthcare services. However, political instability and limited investment in healthcare infrastructure have created significant challenges, particularly in rural and conflict-affected areas. The Ministry of Health and Sports oversees the public healthcare system, but access to care remains limited, especially outside of the major cities. NCDs and communicable diseases (CDs) are both major healthcare burdens. Out-of-pocket expenditure is high and health financing is low, putting healthcare services out of reach for many. External aid plays an important role in supporting Myanmar's healthcare system, with a focus on improving access and quality.

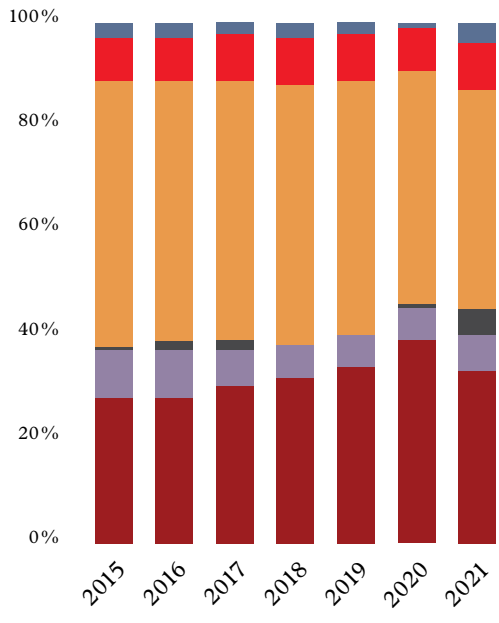
Sources of healthcare financing



Philippines

The Philippines relies on tax-based financing of healthcare, with services mainly provided by government facilities. PhilHealth, launched in 1995, provides financial protection, although high out-of-pocket expenditure remains a concern. With a population of 111 million, 9.7 % of the population is projected to be over 65 by 2050. NCDs account for 69 % of deaths. The country's GDP growth averages 5.7 % and it supports low-income households through social programmes such as conditional cash transfers. Digital transformation and public-private partnerships are emphasised in the country's healthcare strategy.

Sources of healthcare financing



Other
Voluntary prepayments
Out-of-pocket expenses
External aid
Social health insurance contributions
Goverment transfers

Source: Faber Consulting, based on WHO Global Health Expenditure Database

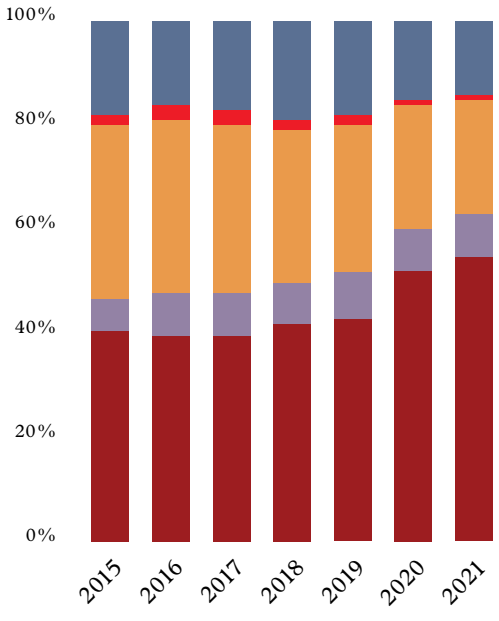
Singapore

Singapore's healthcare system is highly efficient, with government subsidies, insurance and mandatory savings accounts (MediSave). The country is moving towards a value-based system with a focus on primary and community healthcare. With 30 % of the population expected to be over 65 by 2050, NCDs account for 80 % of deaths. Despite GDP growth slowing to 2.2 %, Singapore spends the most per capita on healthcare in the region. The Healthier SG initiative promotes preventive health measures and strong doctor-patient relationships.

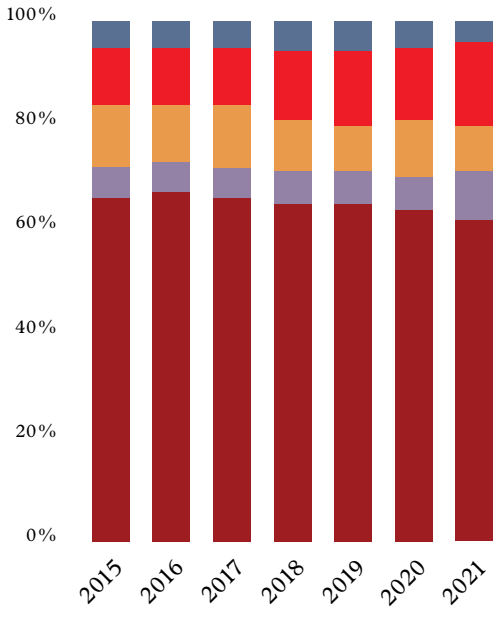
Thailand

Thailand's healthcare system is a mix of public and private sectors, with the government providing basic services through the Universal Coverage Scheme (UCS). Urban-rural disparities remain a challenge, with access to healthcare more limited in rural areas. The government is addressing this through initiatives such as the Village Health Volunteer Programme, which extends services to rural communities. Thailand is focusing on expanding healthcare coverage, improving infrastructure and strengthening primary care.

Sources of healthcare financing



Sources of healthcare financing



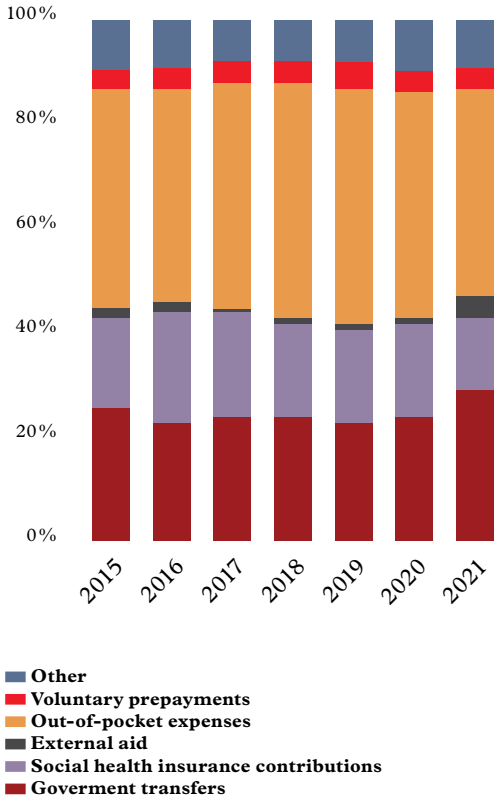
Other
Voluntary prepayments
Out-of-pocket expenses
External aid
Social health insurance contributions
Goverment transfers

Source: Faber Consulting, based on WHO Global Health Expenditure Database

Vietnam

Vietnam's healthcare system is tax-financed, with 87 % of the population covered by public health insurance. However, rural-urban disparities persist. CDs and environmental risks are a major concern, especially for rural and ethnic minority populations. The Ministry of Health is focusing on shifting care from higher-level hospitals to primary healthcare facilities. The sustainability of the system is challenged by low government budgets, rising healthcare costs and declining foreign aid, opening the door for greater private sector involvement.

Sources of healthcare financing

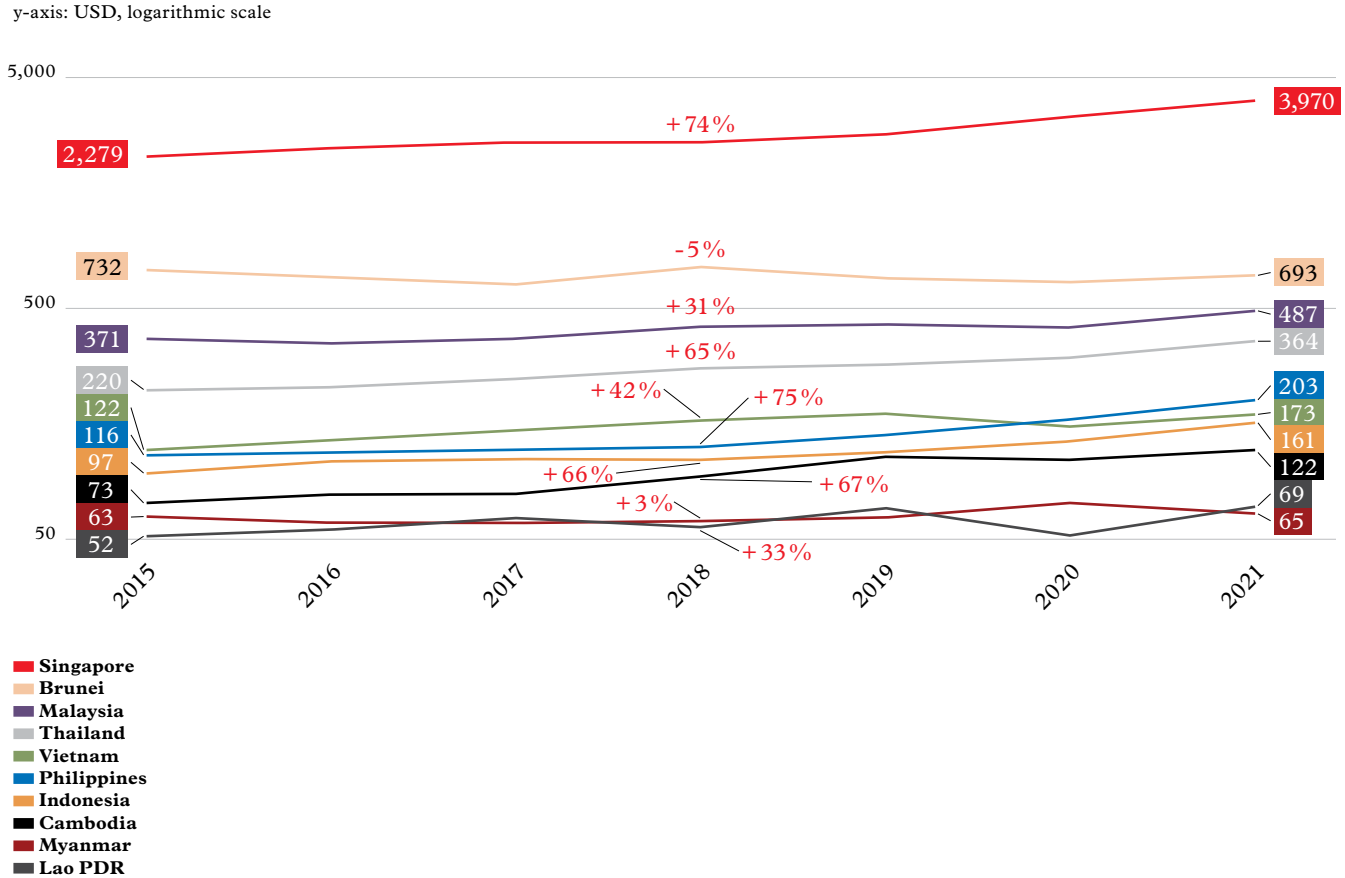


Source: Faber Consulting, based on WHO Global Health Expenditure Database

COVID-19 led to a sharp increase in healthcare expenditure

According to the World Health Organization (WHO), the average total healthcare expenditure in ASEAN is estimated to be around 4.7 % of GDP. Singapore and Brunei topped the list in 2021 with per capita expenditures of USD 3,970 and USD 693 respectively, although Brunei's healthcare expenditure was the lowest of all ASEAN countries at 2.2 % of GDP, while Singapore's was 5.6 % of GDP. Among ASEAN countries, Cambodia spent the highest proportion of GDP on healthcare, at 7.5 %. After 2019, the year in which the COVID-19 crisis began, healthcare expenditure as a share of GDP increased significantly, for example from 2.9 % in 2019 to 3.7 % in 2021 in Indonesia, and from 3.8 % to 5.2 % in Thailand over the same period. Although actual data for 2022 and 2023 are not yet available for all ASEAN countries, there are early indications that healthcare expenditure as a share of GDP declined after 2021 but remained well above the 2019 levels.

Figure 1: Healthcare expenditure per capita in current USD and 2015–2021 growth rate in %, 10 ASEAN countries
Source: Faber Consulting, based on WHO Global Health Expenditure Database

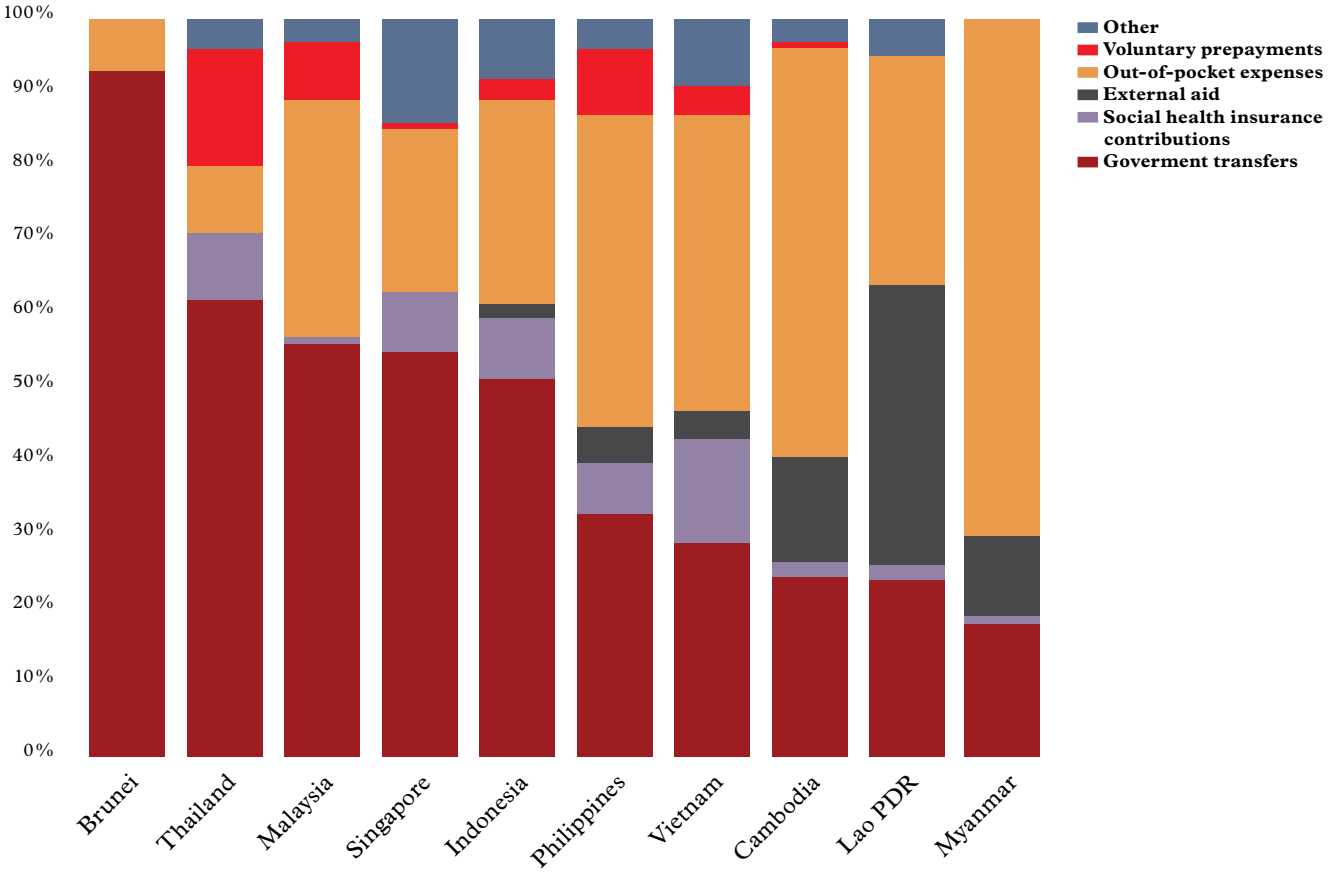


Choice of healthcare financing model and level of economic development largely determine the sources of healthcare financing

In Brunei, Thailand, Malaysia, Singapore and Indonesia, more than 50% of total healthcare expenditure is financed by government transfers. As shown in the country profiles above, this share increased continuously from 2015 to 2021 in Indonesia, remained constant in Malaysia and Thailand, and decreased in Brunei. In Singapore, the share of government transfers also remained relatively constant and increased only moderately during the pandemic.

Out-of-pocket expenditure is very high in Myanmar (70 %), Cambodia (55 %), the Philippines (42 %) and Vietnam (40 %). At 38 %, the healthcare system in Lao PDR is highly dependent on external aid – it can be assumed that without external aid, the proportion of out-of-pocket expenditure would also be over 50 %.

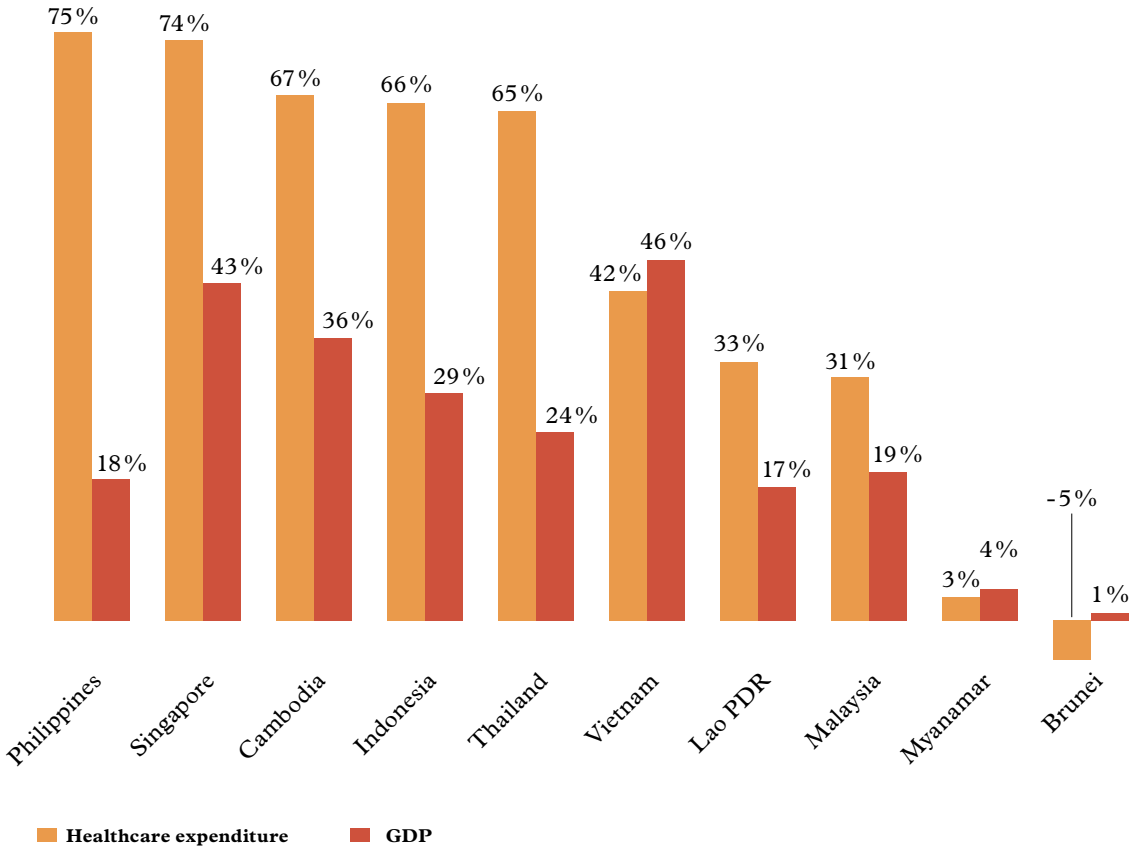
Figure 2: 2021 sources of healthcare financing in %, 10 ASEAN countries
Source: Faber Consulting, based on WHO Global Health Expenditure Database



Healthcare expenditure growth has significantly outpaced GDP growth in ASEAN

GDP growth outpaced healthcare expenditure growth between 2015 and 2021 in only three ASEAN countries, Brunei, Myanmar and Vietnam. In all other ASEAN countries, healthcare spending increased significantly faster than GDP, with the largest relative increases compared to GDP growth in the Philippines and Thailand, followed by Indonesia and Lao PDR. Although these figures appear dramatic, it should be borne in mind that economic growth slowed significantly during the period in question due to the COVID-19 crisis, while much higher healthcare expenditure was required to cope with the crisis. However, even considering the pre-COVID-19 period from 2009 to 2019, healthcare expenditure in Indonesia, Malaysia, Myanmar, Singapore, Thailand and Vietnam grew faster than GDP. In the Philippines, the share remained relatively constant over the period, while healthcare expenditure growth in Brunei, Cambodia and Lao PDR lagged GDP growth.

Figure 3: 2015–2021 per capita real (inflation adjusted) GDP and healthcare expenditure growth rates in %, 10 ASEAN countries
Source: Faber Consulting, based on WHO Global Health Expenditure Database and April 2024 IMF World Economic Outlook Database

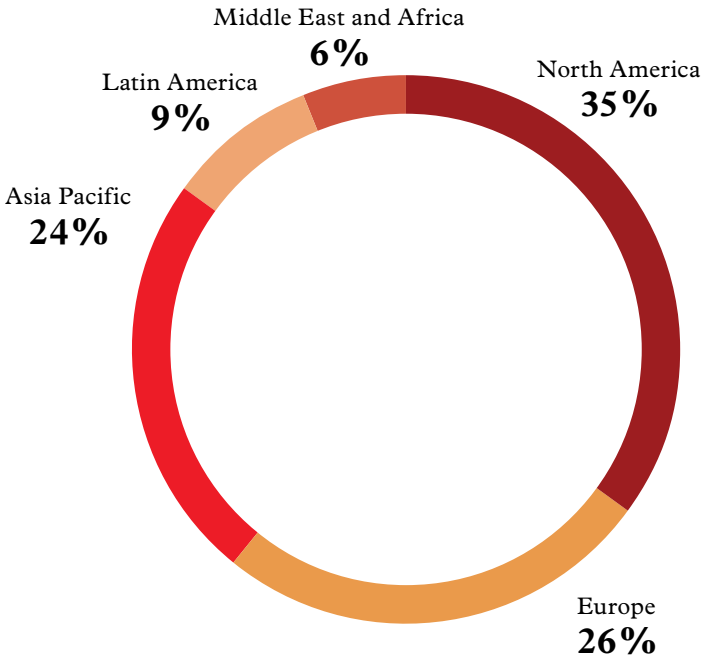


HEALTH INSURANCE

Asia Pacific the third largest and fastest growing health insurance market region in the world

Health has always been a top priority for consumers, often serving as the primary motivation for their initial interactions with insurers. The COVID-19 pandemic accelerated this focus, prompting individuals to not only adopt healthier lifestyles but also to reassess their health insurance coverage. According to a report from Precedence Research[1], the global health insurance industry is experiencing a transformative phase, with its market size projected to grow from USD 2.33 trillion in 2023 to USD 5.12 trillion by 2034, marking a CAGR of 7.42 % over the period. While North America remains the largest health insurance market globally, valued at USD 800 billion in 2023, Asia Pacific is emerging as the fastest-growing region.

Figure 4: 2023 global health insurance market share in %, by region
Source: Precedence Research



ASEAN's health protection gap approaches USD 50 billion

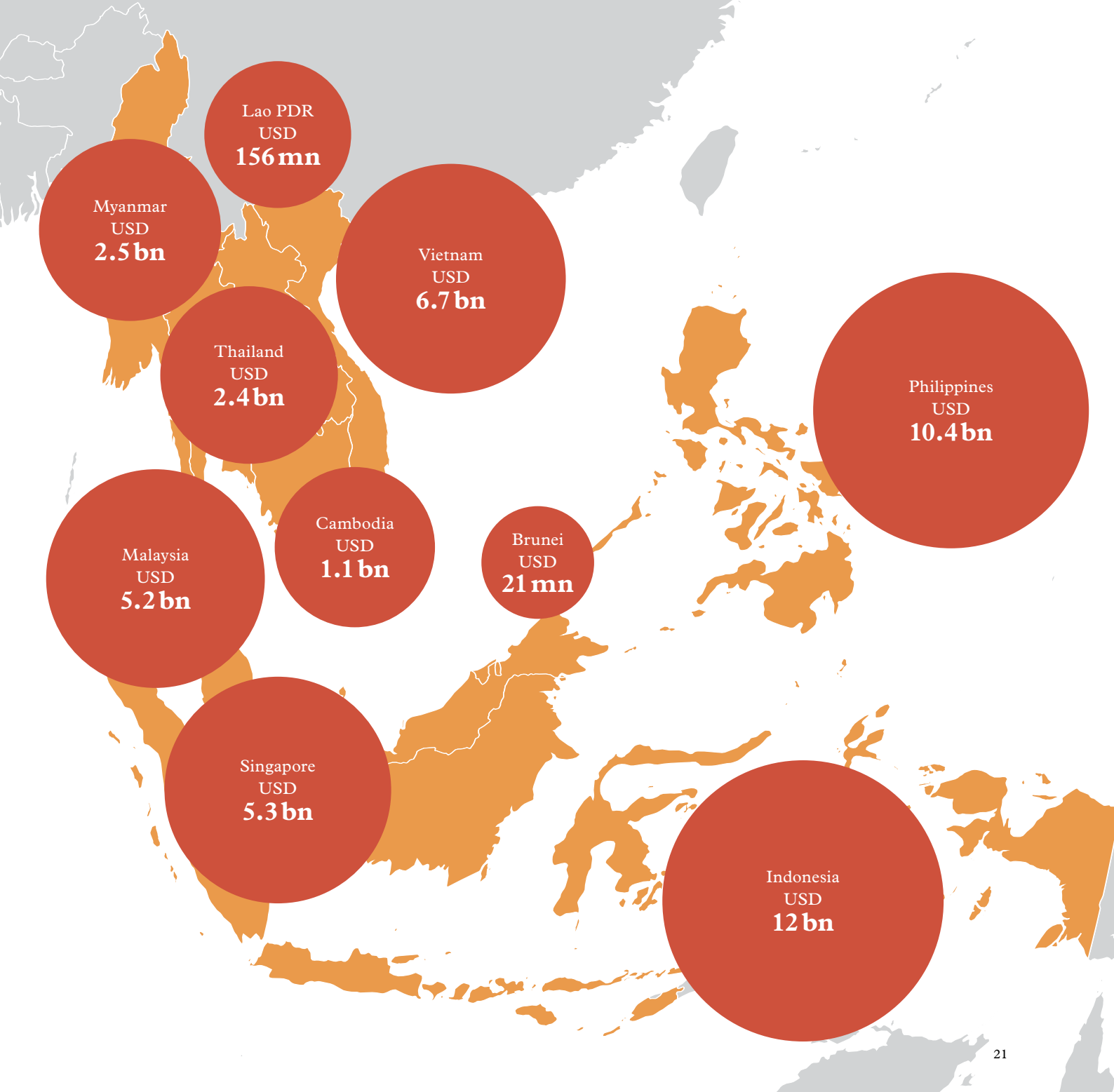
Within the Asia Pacific region, ASEAN member countries in particular are undergoing a health insurance demand shift driven by negative lifestyle changes, rising disposable incomes and literacy rates, increasing internet access, increasing awareness of the value of insurance, improved access to healthcare, improved and new treatments, and investments in healthcare infrastructure.

At the same time, the prevalence of chronic diseases such as diabetes, cancer, cardiovascular issues and obesity—exacerbated by unhealthy eating habits and sedentary lifestyles—is placing unprecedented pressure on healthcare systems. In response, governments and private insurers are ramping up their efforts to meet the growing demand for health insurance. However, despite these efforts, significant challenges remain. Many countries are still grappling with an undersupply of insurance products relative to the burgeoning demand.

As a result, many people in ASEAN lack adequate healthcare coverage and often face high out-of-pocket medical expenses; total out-of-pocket expenses in the 10 ASEAN countries are significant and reached USD 46 billion in 2021. This «health protection gap» poses significant financial challenges for individuals, but also for governments as more people rely on publicly funded healthcare services, putting pressure on government budgets.

1 Precedence Research (2024): Health Insurance Market Size, Share, and Trends 2024 to 2034; https://www.precedenceresearch.com/health-insurance-market

Figure 5: 2021 total out-of-pocket healthcare expenses, 10 ASEAN countries
Source: Faber Consulting, based on WHO Health Expenditure Database



As the region's middle class grows and populations age, the health protection gap is expected to widen unless substantial policy interventions are made. For comparison, in North America, where insurance systems are more mature and employer-sponsored health insurance is common, the health protection gap is significantly smaller. A dual focus on accessibility and affordability will be essential to narrow the protection gap. The role of technology, particularly telemedicine and digital insurance platforms, will be pivotal in reaching underserved populations. Additionally, regulatory frameworks must evolve to encourage public-private partnerships that can expand the reach of health insurance in both urban and rural areas.

High out-of-pocket expenses a challenge for healthcare systems, but an opportunity for insurers

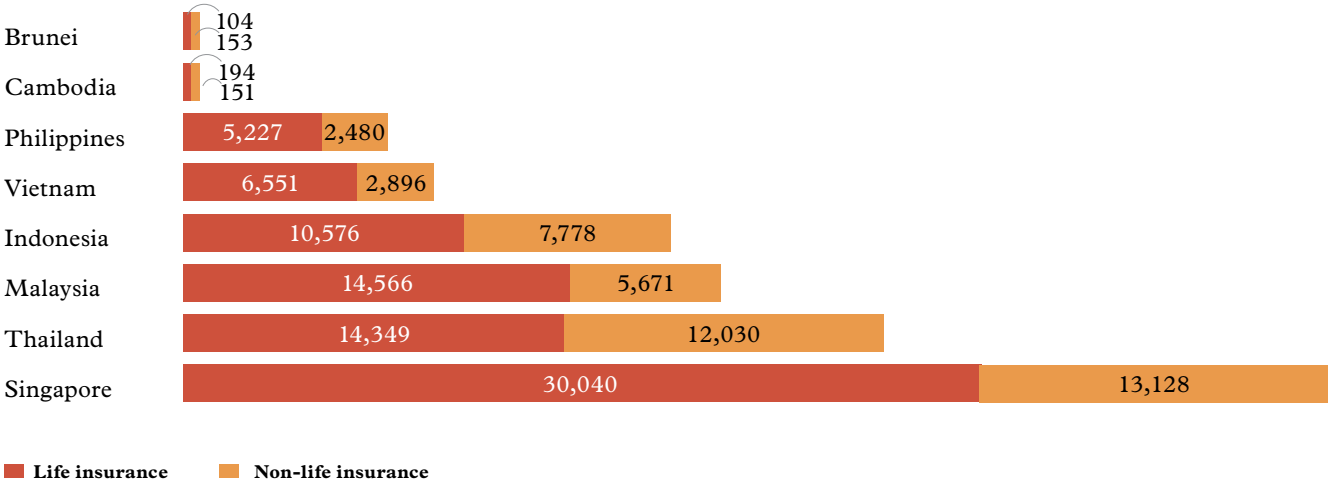
As we have seen, in many ASEAN countries the responsibility for healthcare costs falls heavily on consumers, who bear a significant portion as out-of-pocket expenses. This is largely due to two key factors. First, while public healthcare systems are widespread across the region, they often offer limited coverage. Second, middle-class consumers are increasingly seeking higher quality healthcare that goes beyond what government programmes can provide. Consequently, the demand for private health insurance is expected to rise significantly as consumers look for better protection against these costs.

The COVID-19 crisis led to a surge in the acceptance and use of digital healthcare services such as telehealth, especially for initial consultations and chronic disease management. Healthcare's digital transformation is reaching a pivotal moment, offering insurers new ways to connect with consumers and differentiate themselves from competitors through innovative engagement strategies.

Very strong non-life insurance growth in ASEAN, but a tough year for life insurers

The ASEAN insurance market, with a premium volume of more than USD 125 billion in 2023, is a dynamic and diverse landscape characterised by rapid growth in many segments and markets. In 2023, the region's life insurance segment dominated the market with total premiums of USD 81.6 billion (65 % of total premium volume), driven largely by countries such as Singapore, Malaysia, Indonesia and Thailand. Inflation-adjusted premiums, however, declined significantly year-on-year in Singapore (-16 %), Vietnam (-15 %), Indonesia (-11 %) and the Philippines (-6 %). ASEAN's non-life segment, although smaller with a total volume of USD 44.3 billion, saw significant expansion in markets such as Indonesia (+12 % in inflation-adjusted terms), Malaysia (+7 %) and the Philippines (+7 %), driven primarily by the growing demand for motor and, to some extent, health insurance products.

Figure 6: Selected ASEAN insurance markets, 2023 gross direct premiums, life and non-life business, USD million
Source: Faber Consulting, based on Swiss Re sigma 3/2024, World insurance: strengthening global resilience with a new lease of life, for Indonesia, Malaysia, Philippines, Singapore, Thailand and Vietnam; based on Insurance Regulatory Authorities, for Brunei and Cambodia.



Private health insurance in ASEAN is written by both life and non-life (general) insurers

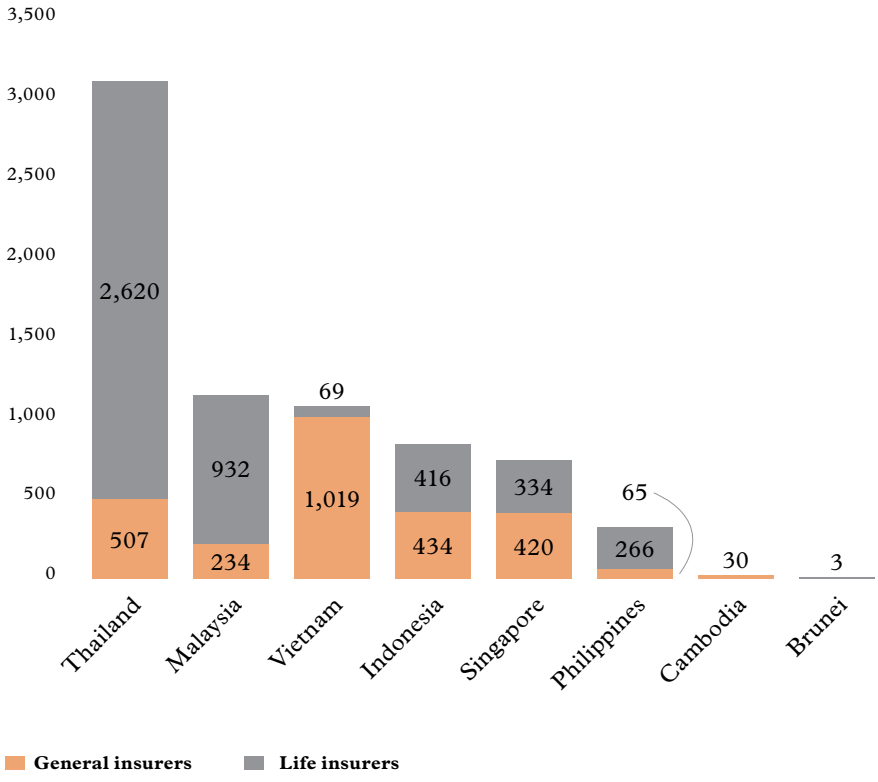
In the ASEAN region, rising healthcare costs, an ageing population and a growing disease burden continue to pose challenges in establishing equitable and sustainable healthcare financing systems. Private health insurance, with its risk-pooling and prepayment advantages, is increasingly viewed as a viable alternative to mitigate the financial burden on individuals and reduce out-of-pocket healthcare expenditure. However, debates continue regarding the effectiveness of private health insurance in providing comprehensive financial risk protection, largely dependent on its structural role, benefit design and the regulatory frameworks governing its implementation.

We estimate that the private health insurance premium written in ASEAN was slightly less than USD 7.5 billion in 2023. The exact premium is difficult to calculate due to a non-standardised statistical base and national characteristics. Thailand is by far the largest health insurance market in the region, followed by Malaysia and Vietnam. Unsurprisingly, private health insurance plays a minimal role in Brunei, where healthcare is almost entirely funded by the state.

By far the largest share of private health insurance is written by life insurers in Thailand, Malaysia and the Philippines, while non-life (general) insurers dominate the health insurance market in Vietnam and Cambodia.

Figure 7: 2023[1] estimated gross written private health insurance premiums, selected ASEAN countries[2], USD million
Source: Faber Consulting, based on regulatory and other industry reports

1 Cambodia: 2022
2 Malaysia: Life Insurers also include Family Takaful Providers; General Insurers also include General Takaful Providers



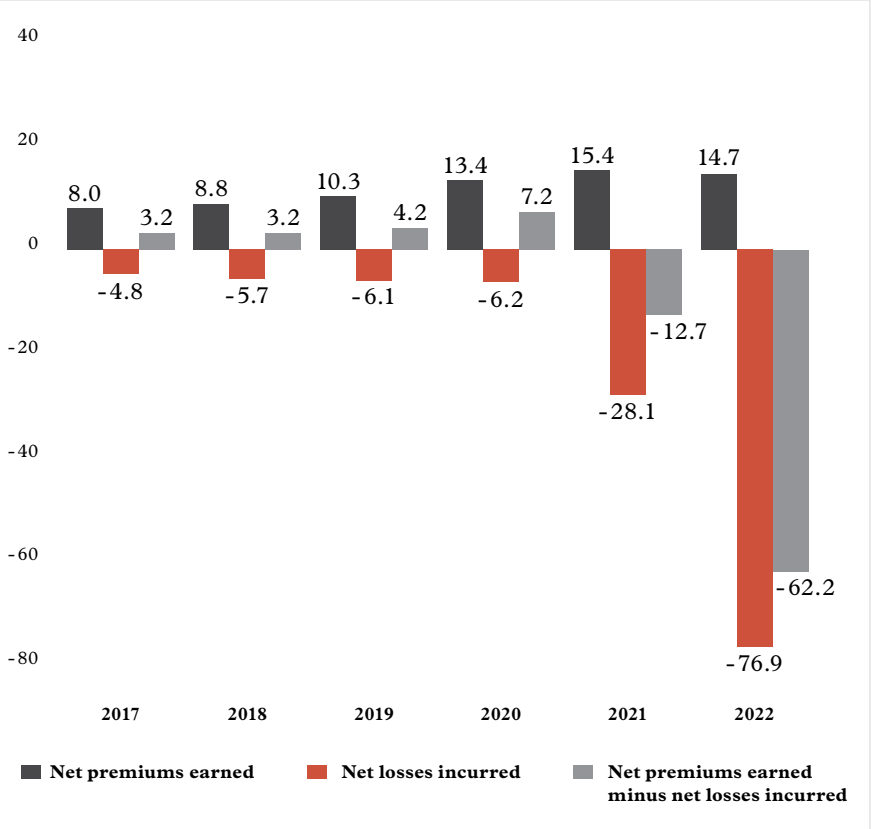
Not all insurers in ASEAN mastered the COVID-19 challenge

Private health insurers in ASEAN have typically acted as intermediaries between healthcare providers and patients, with a focus on cost management. However, this model is becoming increasingly difficult to sustain in the face of changing market conditions. Both healthcare costs and insurance premiums are rising, while competition is increasing and the number of claims is rising. A health crisis in such a market environment can have catastrophic consequences, as shown in the Thailand case example below.

Market development during COVID-19: The Thailand case

As a drastic example of the state of market development, and in particular the challenges posed by the pandemic, it is worth looking at the share of private health insurance written by general insurers in Thailand, the largest private health insurance market in ASEAN, from 2017–2020.

Figure 8: Private health insurance written by general insurers in Thailand, net premiums earned and net losses incurred, 2017–2022, THB trillion
Source: Faber Consulting, based on data from the Thai General Insurance Association



As shown in figure 8, premiums and claims increased sharply between 2017 and 2020. With an expense ratio including commissions of over 40% and resulting combined ratios of between 82% in 2020 and 107% in 2018, the business was already unprofitable in three of these four pre-pandemic years, but insurers were still able to live with these results overall. In 2021 and 2022, however, the results become catastrophic, with combined ratios of 219% in 2021 and 559% in 2022 due to the exponential increase in claims associated with the pandemic.

Several insurers in Thailand faced significant financial difficulties between 2019 and 2023 due to the skyrocketing health insurance losses, particularly those related to COVID-19 policies. In 2022 and 2023, four insurers had their licenses revoked by the Ministry of Finance as the companies were struggling to pay claims under their COVID-19 policies, which promised lump-sum payments during the pandemic. Despite efforts to secure additional financial support, their shareholders refused to inject more capital, leaving them unable to meet their obligations. The Office of the Insurance Commission (OIC) stepped in to facilitate compensation payments through the General Insurance Fund (GIF). As of March 2023, the GIF has approved the payment of COVID-19 claims totalling THB 3.5 billion to a total of 43,354 creditors of the four closed companies. In addition, the OIC has revoked the licenses of five non-life insurance brokers for the fraudulent sale of COVID-19 lump sum insurance policies.[2]

In addition, another insurance company faced legal battles after attempting to cancel over one million COVID-19 policies due to financial strain. However, a court ruling upheld the OIC's decision to prohibit policy cancellations, ensuring that the company had to honour its commitments.[3]

These events caused widespread concern in the Thai insurance sector, particularly as regards the sustainability of pandemic-related health insurance products.

2 Milliman (2023): Thailand General Insurance Newsletter, August 2023 edition.
3 Bangkok Post (June 2024): Insurance regulator's stand on Covid policies upheld

Bright growth outlook for private health insurance in ASEAN

The private health insurance market in ASEAN is expected to continue to grow, driven by a combination of rising healthcare awareness, government initiatives and technological advances. Governments in countries such as Thailand and Indonesia are pushing for universal healthcare coverage, which could further improve access to insurance products. Meanwhile, the integration of digital tools and data analytics is likely to continue to transform the way that insurers manage risk, serve customers and handle claims.

In fast-growing ASEAN countries such as Indonesia, Malaysia, the Philippines, Thailand and Vietnam, with a combined population of nearly 600 million but still low insurance penetration, a significant demographic shift is taking place. Rising incomes and higher levels of education are creating a more sophisticated customer base - people who recognise the importance of financial planning and insurance. As people live longer, a new group of older consumers is emerging, demanding specialised insurance products. In more developed markets such as Singapore, there is a shift towards innovative healthcare strategies, including wellness programmes and preventive care, as well as support for home care for the elderly.

Leveraging technology for efficient claims processes and fraud prevention

One of the key challenges facing insurers in ASEAN is controlling healthcare costs and efficiently managing claims. Rising medical inflation across the region is putting pressure on insurers to adopt more robust claims management strategies. Many companies are now adopting digital claims processing, which speeds up the review and payment process while reducing administrative costs.

With the Asian insurance industry facing estimated fraud losses of up to 35 % of the total cost of medical and health insurance[4], insurers are under pressure from multiple stakeholders to protect their consumers and shareholders by strengthening fraud controls. Technologies such as data analytics, artificial intelligence and machine learning are being used to monitor claims patterns and identify suspicious activity. This helps to mitigate the risk of fraudulent claims, which can have a significant impact on profitability.

4 Asia Insurance Review (May 2023): Unlocking a robust claims fraud risk framework in Asia

Affordable and tailored: Transforming health insurance across ASEAN

One of the key trends in the ASEAN private health insurance market is the shift towards more customised and affordable products. Insurers are increasingly offering micro-insurance and digital health products for low-income populations, particularly in emerging market countries such as Indonesia and the Philippines. This allows individuals to purchase basic health coverage at a lower cost. At the same time, there is a growing demand for comprehensive coverage that includes critical illness, long-term care and lifestyle-related conditions such as diabetes and heart disease, particularly in more developed markets such as Singapore and Malaysia.

To seize the health insurance market opportunity, insurers are already shifting from selling and servicing traditional products to focusing on customers and the health outcomes that they increasingly demand. This means using new technologies and data to work hand-in-hand with customers to deliver preventative care, early intervention and personalised services to improve customer engagement. This shift towards managing health, rather than just covering illness, aims to reduce future claims by encouraging healthier lifestyles. It also means delivering data-driven care more efficiently and effectively throughout an individual's life, for example to reduce the burden and cost of managing chronic diseases.

Digital sales and bancassurance on the rise in health insurance distribution

Digital distribution is becoming increasingly prevalent in the ASEAN health insurance market, driven by high mobile phone usage and growing internet access. E-commerce platforms and mobile apps are being used to distribute health insurance products, allowing consumers to compare policies, purchase coverage and make claims online. This trend is particularly strong in countries such as Vietnam and Indonesia, where younger, tech-savvy populations are more comfortable using digital channels.

In addition to direct digital sales, partnerships between insurers and local banks, known as bancassurance, are gaining traction as a distribution channel. Bancassurance allows insurers to tap into banks' extensive customer bases and branch networks, expanding access to health insurance products in both urban and rural areas. According to Swiss Re[5], bancassurance accounts for an average of 36 % of total life and health insurance premiums in the six ASEAN markets of Indonesia, Malaysia, the Philippines, Singapore, Thailand and Vietnam, although it found that protection-type insurance products, such as medical and critical illness insurance, are often more difficult for bank staff to sell because the products are different from the wealth-related service products typically offered by banks.

5 Swiss Re Institute (October 2023): Bancassurance in Southeast Asia: is the model viable? Findings from consumer and bank representative surveys

Survey results

HEALTHCARE AND HEALTHCARE FINANCING

What is the overall quality of the healthcare system in your country?

At a high level, the majority of ASEAN insurance participants in this year´s survey perceive the healthcare system of their country as satisfactory or partly satisfactory. This implies that people have access to medical treatment and that the quality of this treatment is at least reasonable. However, whether they have access to this treatment «without suffering financial hardship» – as per the defined, universal goal in the Universal Health Coverage (UHC) principles of the World Health Organisation (WHO) - is an assumption that can be debated not only for ASEAN countries, but also for other countries around the world.

Many participants pointed out that their healthcare system performed well during COVID-19. For example, South-East Asia suffered less COVID-19 incidences than many other countries, and some ASEAN countries, including Malaysia and Thailand, experienced a sizable level of «medical tourism» from neighbouring countries and further afield.

This positive assessment of ASEAN healthcare systems notably comes with two key caveats.

Firstly, participants highlighted that their rating is a gross generalisation of the current situation in their market and that access to treatment is also a question of location. In large municipal centres, access to medical facilities is easier to attain than in rural regions. And even in a country like Singapore with a strong healthcare system, a patient's wealth impacts the quality of treatment available to them.

Secondly, and more importantly, participants stressed that their ratings reflect a time snapshot – healthcare systems are largely satisfactory now, but the outlook may be different. ASEAN healthcare systems are under stress from changing demographics, new types of diseases and changing disease prevalence, deteriorating lifestyle patterns and increasing expectations of the population, and from what is generally subsumed under the term «medical inflation» – defined as the rising cost for advances in treatments and procedures, and its increased availability and usage.

Finally, healthcare systems also rely on government support – at least for the public healthcare sector. This part of the healthcare system may be deemed satisfactory or already flawed, but there is a threat that it could become even less dependable in the mid- to long term.

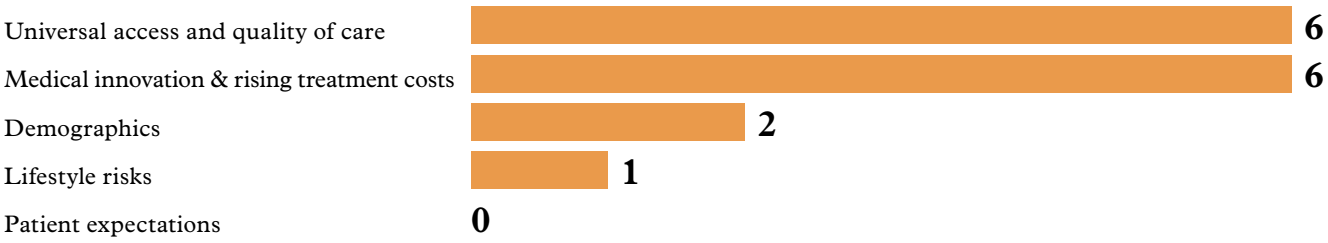
«The Philippines suffers from unequal quality and access to health services between urban and rural areas, and in particular from an overall shortage of health professionals such as doctors and nurses. The reputation of Philippine health personnel is excellent, and many well-trained Philippine health professionals have left the country to work abroad.»

Michael F. Rellosa, Executive Director,
Philippine Insurers and Reinsurers Association (PIRA)

«In Brunei, we are blessed with a benevolent government that provides free healthcare to all citizens, not only absorbing the impact of inflation, but also paying for treatment abroad if certain services can't be provided in Brunei. We therefore focus on providing health takaful protection (insurance) for foreign workers, which is a legal requirement. We have seen and expect further growth in this segment as more Government Linked Companies are expected to take up takaful protection (insurance). In addition, the health protection (insurance) limits for foreign workers will be increased from 10,000 Brunei dollars to 100,000 Brunei dollars expected in 2025.»

Shahrildin bin Pehin Dato Jaya, Managing Director & CEO,
Takaful Brunei

What are the main challenges facing the healthcare system in your country?



ASEAN healthcare systems are not confronted with a single challenge, but with a multitude of challenges – many of which are unrelated to insurance. Participants differentiated between the public healthcare system, which is largely government financed, and the private healthcare system, which is partially financed through insurance, takaful protections, and also through out-of-pocket expenses.

In most countries, the public healthcare system tries to guarantee a basic supply or access to healthcare, often by running a chain of public hospitals. However, such systems struggle with the sole or primary funding of government expenditure on the one hand, and medical inflation on the other. As governments seek to reduce or contain the associated cost burden, public healthcare systems suffer from issues such as accessibility (the discrepancy between rural and urban access to treatment), patients facing long waiting times and queues for treatment, and a low or deteriorating quality of care as either public investments are insufficient to achieve or maintain the service, or as there is a constant drain on the system from doctors, specialists and nurses switching to the better renumerated private system.

On the private side, by contrast, the main concern is cost, driven by two factors: medical inflation, which outstrips inflation, and opaque costs for treatments, where there is no apparent correlation between the quality of the service provided and the cost incurred. As a result, claims ratios are high and rising, translating into recurrent rate increases which threaten the affordability of the private system and call into doubt efforts aimed at extending the private system to lower-income segments of society and broadening health insurance penetration.

Furthermore, participants pointed out that the healthcare systems of all ASEAN countries are under stress from increasing disease prevalence. For example, the prevalence of lifestyle related illnesses has increased, including in Malaysia where the prevalence of obesity and diabetes mellitus is estimated to have risen from 17.5 % in 2023 to 21 % in 2024, while the prevalence of Malaysians regarded as obese has escalated to approximately 45 %. In addition, other non-communicable diseases (NCDs), including cancer and cardiovascular diseases, are on the rise as populations age.

«One of the most significant challenges facing Vietnam's health sector is the disparity in access to and quality of medical services between rural and urban areas. This uneven distribution often leads to overcrowding in urban medical facilities. Although the government has made substantial investments in rural healthcare in recent years, considerable work remains to address these inequalities.»

Vina Re

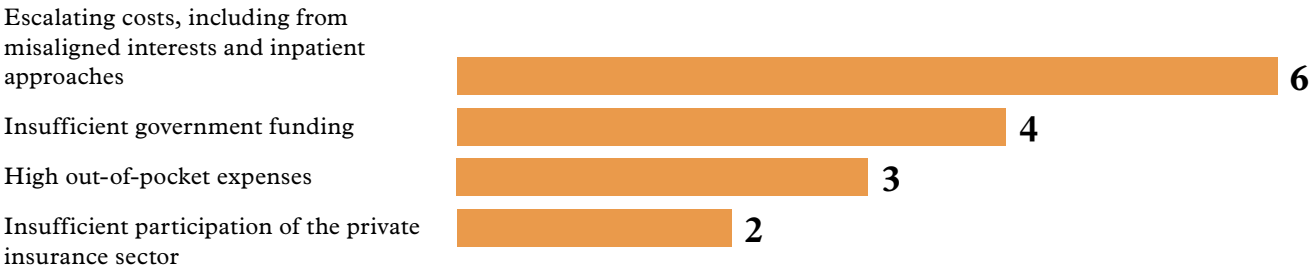
«Indonesia's national health insurance scheme, Jaminan Kesehatan Nasional (JKN), was introduced in 2014. The scheme, which is administered by a single agency, the Social Security Agency for Health (BPJS-Kesehatan), consolidates several health insurance programmes. Although more than 80 % of the population is covered by the scheme, major challenges are access to quality healthcare, especially outside urban areas, and the lack of standardised benefits and tariffs.»

Christian W. Wanandi, President Director, Asuransi Wahana Tata

«Changing demographics and unhealthy lifestyles are major challenges for Brunei's health system. In 2022, more than 34 % of adolescent females and more than 30 % of males were obese, the highest proportions of any country in Southeast Asia. Even more worrying is the high rate of over 24 % for male children, which is the 12th highest in the world.»

Klaus Tomalla, General Manager, National Insurance Company Berhad

What are the main intrinsic deficiencies of the healthcare financing system in your country?



There was significant recurrence across ASEAN as regards the weaknesses of healthcare systems.

In public healthcare systems, participants shared that costs are rising faster than GDP or inflation. Government budgets are strained and there is no diversified income for the public system, i.e. it is mostly 100 % government financed. There is no straightforward remedy. In light of escalating costs, affordability of healthcare remains a challenge for the poor, and even for the middle class. Increasing out-of-pocket expenses and shifting part of the responsibility for cost containment to the patient is therefore politically not an easy task. Participants also emphasised that there is too much focus on inpatient treatments, while in many cases outpatient treatment could be more cost efficient.

Alignment of interest – or, to use an insurance term, a lack of «skin in the game» – is also an issue in the private healthcare system. Treatments are often perceived as too expensive and private hospitals and their providers are accused of overselling, overcharging and thereby incurring wastage and of abusing the system. Participants in several ASEAN countries were critical that:

- The purchaser, i.e. the patient, and the payer, i.e. either the government or insurer, are disconnected – the patient has little interest in controlling the cost that the payer will have to cover.
- The payer, in this case the insurer, and the provider, i.e. the hospital, are disconnected – insurers cannot control what hospitals charge. In fact, in this compartmentalised system, private hospitals have no incentive to contain their cost.

As an example of the disconnect between patient, payer (insurer) and private hospitals, Malaysian participants highlighted that treatments can have different costs depending on whether or not patients are insured – and in fact, those who pay for a service out of their pocket, are likely to be charged less or to receive a more focused treatment.

As a result, private health insurance rates keep rising. This is particularly painful for elderly insureds of 60 years and older, as in addition to facing medical inflation and the lack of cost control within the system, they are also in a phase where rates are higher due to their risk profile. In the worst case, as insurers try to contain rising claims' costs, they could even lose their coverage.

«Generally, the quality of care is good in Malaysia. However, the public system suffers from chronic underfunding due to its non-diversified income from government sources. The results are long waits, a disparity in the quality of the facilities and a constant drain on the resources as nurses and doctors move to the private sector for better pay. The private sector, by contrast, has no incentive to contain cost, resulting into an abuse and wastage of resources as well as inflated claims. There is no apparent correlation between the quality of the outcome of the treatment and its costs, which ultimately contributes to a steady increase in insurance rates.»

Mark O'Dell, CEO,
Life Insurance Association of Malaysia (LIAM)

If you could make one recommendation to improve the system, what would it be?

Although cost control was a component of all improvement recommendations, there was no single recommendation advocated by participants - this can be no surprise given the widely diverging healthcare structures and approaches across ASEAN countries. Recommendations are grouped below into a set of likeminded approaches.

In countries including Cambodia, the Philippines and Vietnam, recommendations focused on expanding the healthcare system to tie in the rural regions that are still struggling to provide access to healthcare. However, being recognisant of medical inflation, proposals included the need to invest more in prevention and education to reign in the rapid rise of NCDs.

Another key recommendation was to address escalating costs related to the overselling or overconsumption of the system. Examples discussed included unnecessary treatments and variable prices for drugs and medical equipment. It was pointed out that in Malaysia, for example, the cost of certain drugs can vary by a factor of 32 between the cheapest and most expensive hospitals.

To address this challenge, participants recommend the instalment of a data platform to register medical claims and patient data to better understand treatment costs, prevent abuse and reduce inefficiencies. This necessitates close cooperation between governments, insurers and hospitals, and may incorporate the introduction of a Diagnosis-Related Group (DRG) system, as originally developed in the US in the 1980s and, in ASEAN, as is already used in Thailand.[6]

Furthermore, in Malaysia and Thailand, insurers are demanding a greater alignment of interest between patients and insurers. In Malaysia, the government has correspondingly introduced a 10 % co-payment option for patients on all treatments. The aim of this option, which has been widely applauded by insurers, is that patients who opt for co-payment have a financial interest in controlling the treatment cost.

Finally, to reduce or contain costs, participants in several markets recommended a greater use of digital technology and telemedicine. Recommendations were also made for more outpatient care, as in many ASEAN countries there is too much focus on more costly inpatient treatments.

6 The World Bank Group; 2020, Transition to Diagnosis-Related Group (DRG), Payments for Health: A DRG system classifies hospital cases into groups that are clinically similar and are expected to use similar amounts of hospital resources. When used for payment, the amount per episode of care is fixed for patients within a single DRG category (based on average cost), regardless of the actual cost of care for that individual episode, but varies across DRGs.

«The collaboration between public and private healthcare provides the population with a reliable service - as underlined by the medical tourism coming from neighbouring countries and seeking treatment in Malaysia. However, the escalating costs on the private side of our healthcare system are a concern that the government is trying to balance by introducing the co-payment option of up to 10 % for private treatments. In addition, with the rising prevalence of diseases such as obesity and diabetes, the necessity for prevention becomes paramount - also in trying to contain costs.»

Marcel Omar Papp, Head Retakaful,
Swiss Re Retakaful

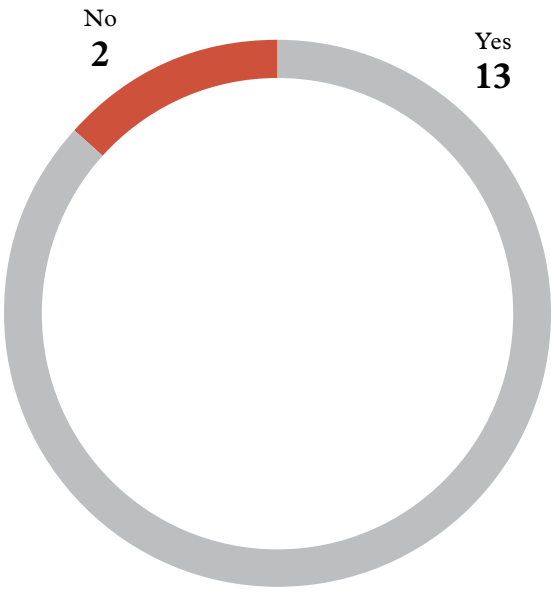
«Insurers have only a few options to deal with the escalating claims costs. The most obvious answer is a repricing of the risk. However, to bring down the cost and thus insurance premiums, it needs the broader collaboration of all stakeholders including a strong support from regulators in the health and finance departments. The entire health service delivery eco-system is not efficient and transparent. Areas to look into include a more coordinated and centralised medical information database and clarity of medical treatment cost by groupings instead of detailed itemisation (this appears to be transparent but is actually more complicated and difficult to understand.) Recent introduction of co-payments into policyholders cover may be one of the first few steps to create better awareness for consumers to be mindful of their treatment cost and focus on necessary treatments.»

Ng Kok Kheng, CEO,
Great Eastern General Insurance (Malaysia) Berhad

«The Malaysian healthcare system performed well during the pandemic. However, the public part of the system is under stress from medical inflation which continues to rise by 10 - 15 % per annum. Equally, the private sector, which provides adequate services to its insureds, is also confronted with rising costs, resulting into higher rates. The Government, Bank Negara, associations, insurers and hospital operators are collaborating to gain a better understanding of the costs, its drivers and to improve access to the underlying data for a better long-term outcome.»

Antony Lee, President,
General Insurance Association of Malaysia (PIAM)

Has COVID-19 influenced the development of the healthcare system in your country?



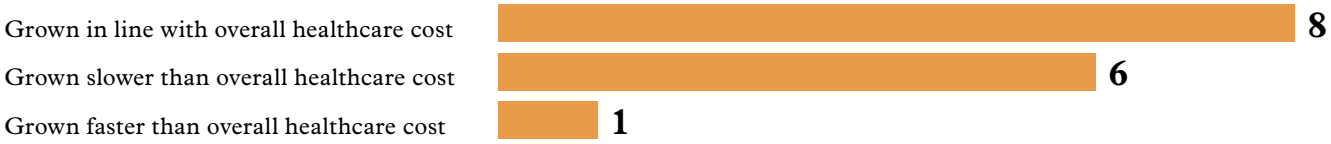
Overall, participants observed that ASEAN healthcare systems have benefited in certain aspects from COVID-19. According to the majority of participants, the pandemic raised awareness of the need to take precautions for one´s health and that health should not be taken for granted. As a result, people were perceived to pay more attention to hygiene and sanitation. Investments in healthcare facilities also increased, and in some countries employment in the healthcare sector rose. The pandemic also reportedly led to an increase in demand for health insurance.

Nevertheless, opinions were split as regards how lasting this impact has been. The pandemic was also a significant disruption for ASEAN healthcare systems. For example, people were afraid to visit hospitals as they feared catching the virus. Elected treatments, where patients could decide on the date of a surgery, were delayed due to fear of the virus and reduced workforces. Only the more critical treatments took place. This initially led to less but more severe health insurance claims, followed by a catch-up phase from 2022 to 2023, whereafter claims plateaued. Participants noted that the initial delays in treatment ultimately led to higher costs and claims.

The effect on insurance buying due to COVID-19 is hard to determine as too many factors are at play. Certainly, during and in the immediate aftermath of the pandemic, sales went up. Since then, sales have slowed down or plateaued. Other factors, such as the steady increase in premium rates, may create a contrary effect.

One lasting impact of the pandemic reported by participants was telemedicine – this was offered by practitioners and insurers decided to maintain the coverage post-pandemic. Similarly, hospitals introduced new booking systems which have not been disbanded.

How has health insurance penetration developed in relation to the rising healthcare cost, and what is needed to increase the uptake of private health insurance?



Advances in health insurance penetration are out-paced in many ASEAN markets by rising healthcare costs. Participants described that affordability for consumers remains a key issue and that this will not improve as long as insurance rates keep rising as fast as they have done in recent years. Rates follow healthcare costs, so unless rising healthcare costs and medical inflation are reigned in, health insurance penetration is unlikely to increase significantly going forward.

Health insurance buying takes place in markets and segments where rising incomes enable consumers to purchase insurance coverage, either as a benefit of their employment compensation package or on their private behalf. As the public system struggles with capacity and quality issues, and in financing the healthcare needs of the population, consumers very much recognise the advantages of the private system. Thus, in the more affluent parts of society, sales have risen in markets such as Malaysia and Thailand, during COVID-19 and ever since. This applies to full cover health insurance, as well as to critical illness, mental health and disability coverages.

However, the inability to control healthcare costs threatens to wipe out any advances in health insurance penetration and to drive people back into the public system. In fact, health insurance might have reached a turning point, in particular for elderly insureds. As rates continue to rise well above inflation, insureds are struggling to finance their premiums. Elderly insureds additionally have to digest a rise in rates as they have become a higher risk. At the same time, insurers are facing rising claims and deteriorating profitability. Competition for the better risks is high. Younger, loss-free insureds, for example, are offered incentives to change insurer, leaving others with a cohort of poorer risks, forcing reductions in service. It is feared that some insurers may exit the line.

Where consumers have private health insurance as part of their employee compensation package, employers often try to contain the rising cost of the coverage by reducing the scope of the cover, introducing lower limits or adding exclusions. Insureds then might need to buy top-up products for a more comprehensive protection.

«Overall, we see a slight improvement in health insurance penetration. The pandemic has heightened awareness for health protection. In addition, the middle class is seeing some wage increase and we see an uptake in health insurance purchase. However, as rates keep rising, driven by higher costs, we see innovative «top-up» products, where individuals are buying medical insurance on an excess-of-loss basis with a much higher deductible, possibly to complement the cover that the consumer already enjoys with its employer.»

Faris Davidson, Managing Director,
Gallagher Re Labuan

What is the health insurance situation of the low-income segment in your country, and has it improved in recent years? How? Role of government?

Most ASEAN countries follow a hybrid healthcare system, whereby the low-income segment is served by public hospitals, while the middle- to high-income segments may either buy themselves health insurance or are covered through their employer. An exception, for instance, is Brunei, where healthcare is predominately government financed for all income segments.

Participants described how public healthcare systems have deficiencies, including low accessibility in rural regions, long queues to access treatment and disparate quality. Usually, a public system has the government as its dominant income source, sometimes complemented by out-of-pocket patient expenses. Since public funds are often overstretched and as healthcare costs keep rising, in particular given medical inflation, governments aim to reduce, rather than to expand, their involvement.

From an income segment perspective, most ASEAN countries are characterised by a threefold healthcare solution. The low-income segment is as far as possible served by the government. As our survey participants phrased it, there is no better solution. The middle-income segment of society is often in a sandwich position. Theoretically, the private sector should cover this segment as far as possible through employer group health schemes. Finally, the upper-income segment is covered through a group health insurance scheme or can choose to buy themselves private health insurance.

Efforts to increase the private sector's involvement in the low- and the mid-income segments, and to relieve the public sector from cost pressures, however, have been thwarted in the current market environment. The reason is relatively simple, as most participants stressed: medical inflation far exceeds general inflation or average increases in wages. Thus, the outlook trend reported by participants is that more people are pressed to leave the private healthcare system – at least in the mid to long term, due to rising costs and an increasing lack of affordability.

Governments in many ASEAN countries have been active in trying to reduce the healthcare cost burden. For example, more investments are being funnelled into disease prevention, including awareness programmes, and in particular to fight rising NCDs. Furthermore, more attention is being given to outpatient treatments, which are often less costly than inpatient treatments. And finally, continuing the positive experience from the pandemic, governments are maintaining and expanding telemedicine treatments.

«In line with its commitment to promote an enabling environment for the development of health microinsurance products, the Insurance Commission of the Philippines established the Health Microinsurance Framework in 2016. The framework aims to complement the Government's universal health care programme through the development of affordable products which include full or partial coverage of curative services or cash assistance for medical costs especially for underserved sectors of the population.»

Allan R. Santos, President and CEO, Nat Re

How has medical inflation developed in your country compared to the CPI in recent years?

According to the WTW's 2024 Global Medical Trends Survey, medical costs in Asia Pacific surged by 9.9 % in 2023 and are projected to rise by a similar percentage in 2024. Net of inflation, that reflects increases of 5.6 % in 2023 and 7.0 % in 2024.[7] This resonates well with the observations in this survey, as most participants observed an increase in medical inflation well above general inflation. In fact, all of the participants who provided an estimation, reported a rise in medical costs in the range of 10 % to 15 %, with some estimations even exceeding 20 %.

The main cost drivers identified in the WTW report were a steep rise in musculoskeletal disorders, the top condition by claims incidence, followed by cardiovascular diseases and cancer, while mental health was the fastest rising condition by incidence and cost. New medical technologies and the overuse of care were seen as other causes of growing healthcare expenditure, as was the exclusion of certain diseases and wellbeing provisions from coverage, resulting in health deterioration.

7 2024 Global Medical Trends Survey, WTW, November 2023

Table 1: Global medical trend 2022–2024, globally and by region
The growth in medical costs is projected to decline further or remain unchanged in most regions in 2024.
Source: 2024 Global Medical Trends Survey, WTW, November 2023

	Gross			Net**		
	2022	2023	2024 (projected)	2022	2023	2024 (projected)
Global*	7.4	10.7	9.9	-0.3	5.2	6.5
Latin America*	10.5	12.4	11.6	2.7	6.3	7.9
North America	8.0	9.8	9.4	0.5	5.6	7.1
Asia Pacific	7.2	9.9	9.9	2.2	5.6	7.0
Europe	6.7	10.9	9.3	-2.4	5.0	5.9
Middle East and Africa	9.8	11.3	12.1	2.6	4.2	6.8

* Global and Latin America numbers exclude Argentina and Venezuela
** Net of general inflation

Survey participants saw higher costs for pharmaceuticals as a key cost driver, compounded by rising import costs due to weaker domestic currencies. Higher wages, inflation, technological advancements and new treatments further drove up costs. Notably, the main cost driver identified by participants was the overuse or overconsumption of the system, specifically the prescription of unnecessary treatments and the need for private hospitals to be profitable.

HEALTH INSURANCE MARKET

What is your outlook for health insurance premium growth in 2024/25?

According to participants, premium volume is still predominantly on the rise and in some countries will even outpace medical inflation. Premium volume continues to benefit from the impact of COVID-19, when demand for medical protection jumped in some markets as consumers recognised the importance of health protection. Improved awareness is expected to continue to contribute to enhanced, although plateauing, demand.

Where premium volume is rising, growth is driven not just by higher demand, but also by higher rates and expansion of coverage. The concern, however, is that premium growth could soon peak as drastic rate increases drive policyholders back to the public system. As one participant pointed out, health insurance is not an old product yet in ASEAN, the medical population is only 25 years old and the cohort of «65 year plus» insureds is still relatively small. However, looking forward, insureds will enter that age group in ever greater numbers – and as that happens, they will be hit by substantial rates increase and might decide to leave the private and re-enter the public system.

Has risk-adjusted pricing in health insurance increased since 2021? Why and by how much?

ASEAN markets differ in their ability to increase rates in light of rising claims due to medical inflation. Where competition is perceived to be fierce, such as in Cambodia or Thailand, rates are under pressure, while in the government-driven healthcare system of Brunei, rates are seen as stable. Rates are up in markets including Indonesia, Malaysia and the Philippines.

Health insurance is often written in combination with life policies and is used by life insurers as a «rider» for the latter, encouraging consumers keen to buy health cover to also buy a life insurance policy. As a result, health policies could be priced lower than necessary.

Where rates are up, increases are often substantial. Participants for Malaysia, for example, observed rate increases in the range of 20 – 30 % for general insurers that renew health policies annually. This was particularly the case for new policies, while for in-force policies, rate increases might have remained more moderate. However, to «soften» the impact of higher pricing, insurers sometimes broadened the overall coverage.

Furthermore, we need to differentiate between general insurers that also sell health insurance and life insurers that typically write the dominant share of the health market. While general insurers are able to renew annually, and thus to simultaneously reprice, life insurers can only reprice in-force policies every two to three years. Price increases by general insurers can therefore appear more moderate over a short time period.

Drastic price jumps are problematic not only for insureds, but also for insurers. Insureds might choose not to renew. Insurers see the good risks leave, while higher risks stay. As previously described, competition for good risks can leave the former insurer with a closed block of high risks that is prone to experience higher claims inflation.

«Rates for new policies underwritten may increase from 15 % to 20 % year-on-year, to reflect the rising costs. We aim to cushion that effect by recommending to our cedants that with the increased price to also include enhanced benefits. Policies are typically capped at 100,000 – 150,000 ringgit per person per annum. That might be insufficient for a specialised cancer treatment. We therefore recommend to cedants to include additional benefits like precision cancer treatment in the higher priced policy under the same limit.»

Nizam Yahya, Head of Malaysian Re Retakaful Division

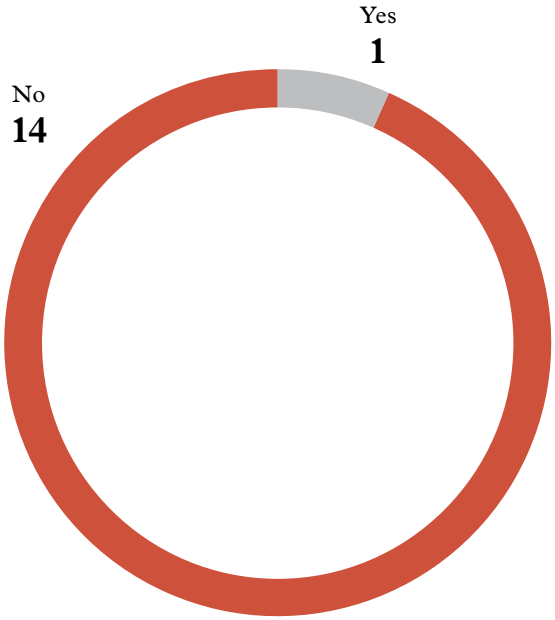
How has profitability developed since 2021?

For most ASEAN insurers, the profitability of health insurance has deteriorated since COVID-19. During the pandemic, people avoided hospitals as far as possible because they feared contracting the virus. Thus, many elective treatments were delayed, initially causing a substantial decline in claims. Since the pandemic, delayed treatments rebounded, adding to the claims cost, while at the same time inflation rose, medical inflation accelerated and ASEAN insurers began to see the impact of relatively young insured cohorts entering older age groups.

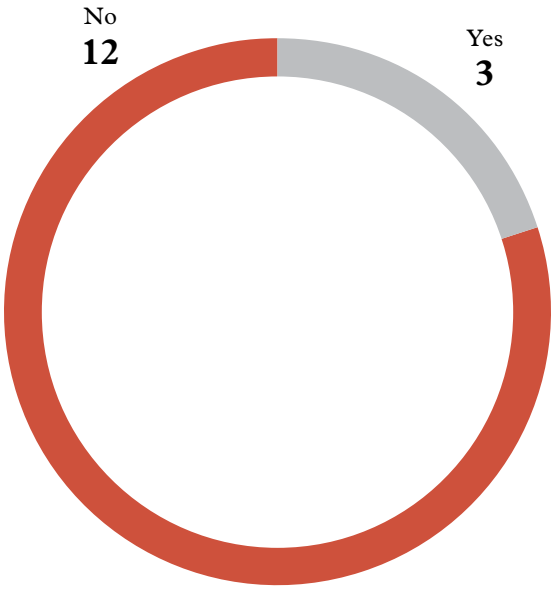
As a result, participants described the health line as «at best marginally profitable», with profitability having declined or remained stable over the last two years. The line was described by one participant as «the least profitable after motor». A leading expert in life insurance reported the claims ratio in his country to be «close to 100 %». Without a remedy to spiralling costs in sight, the outlook for the line's future is characterised by insurers as relatively bleak. As several participants added, health is often written as a rider to sell life policies and subsequently, is often cross-subsidised by life business.

Have new players entered the market in the last two years or has capacity increased?

New players entered market?



Capacity increased by existing players?

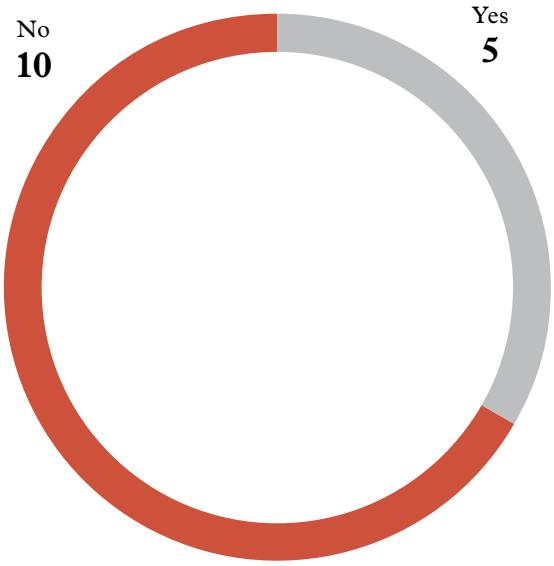


Almost all participants saw either no new players enter the market or just some consolidation of existing players. The main reason for this was reported to be the low profitability of health insurance in ASEAN and the bleak outlook. Unless the causes of escalating costs are addressed, no change is in sight. Thus, there were only a few isolated pockets of capacity growth from new players, for example an international player entering the market and life insurers taking advantage of higher demand for the health insurance to build their footprint in life insurance through bundled products of both lines.

Instances of new capacity entering the market were isolated. Life insurers have tried to build portfolios of investment-linked health products, but the outcome is unclear as medical inflation outgrows the likely investment return.

Some hope was noted in the form of announcements to provide «digital licenses» to purely digital players entering the market with an online approach to distribution and claims. However, these players are not expected to provide general health insurance products, but rather top-up solutions or policies with low per annum coverage limits.

Have new products entered the market in the last two years that have helped to extend coverage, in particular to the low-income segment?



The majority of participants observed no substantial product innovations in health insurance in the last two years.

However, there were some reports of incremental cover additions to standard policies. For example, following the success of critical illness products, top-ups have been launched to provide coverage for mental health and disability, or even for precision cancer treatment and alternative treatments in different countries.

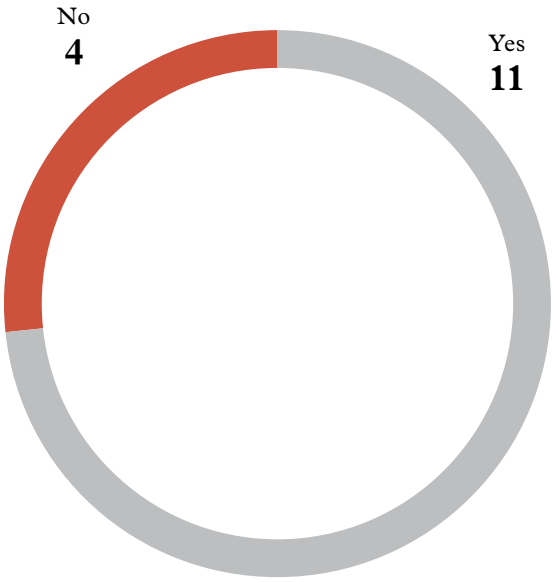
Buying additional limits was another observed trend. Health insurance products in ASEAN often come with an annual limit. In Malaysia, for example, policies are frequently limited to MYR 100,000 (approximately USD 23,000) per annum. However, insureds can buy additional coverage by extending that limit, for instance through excess-of-loss policies with a high deductible. Purchasing extra limits was also noted as a trend for group health policies. To contain hefty rate increases, employers may reduce the annual limits of group policies. Limits can vary according to the seniority of employees, such as one, two or three times the annual salary. Insureds can opt to purchase an additional limit, for example to increase their limit to four times their annual salary.

Participants highlighted a dilemma as regards extending coverage to low-income segments and annual limits. Such products would typically involve a low limit to ensure affordability. However, if costs keep soaring and hospitals continue to overprescribe treatments, specifically if patients are insured, the protection offered by products with low annual limits may be insufficient.

«We are concerned about the potential underinsurance of our customers. In order to manage the cost of insurance and thus make it easier for our customers to maintain their cover in times of rising inflation, we offer our customers an interest-free insurance premium repayment scheme through our Group's bank credit card facility. This allows customers to pay their insurance premiums in monthly instalments using the bank's credit card facilities.»

Jef Tio Soon Keong, CEO,
Campu Lonpac Insurance

Have you seen measures by insurers to control the cost of health insurance?



Participants described the strategies that insurers are applying to combat rising costs in the sector.

The most obvious strategy is to re-price business to reflect the higher claims cost. However, this strategy may be detrimental to the long-term viability of the business as insureds may be forced to cancel policies and return to public health providers in increasing numbers.

Secondly, insurers may opt to reduce risk. Examples include applying exclusions, moving out of group policy business and only underwriting individual health business, only offering high-end products going forward, drastically reducing the annual limit of policies, applying stricter guidelines for certain pre-existing conditions, or even exiting the line.

The third strategy is cost control. Some participants pointed out that they are working with loss adjusters to scrutinise hospital bills, which often seem inflated. This involves renegotiating with the hospital and pressuring them not to overcharge, to provide more transparency and to apply more standards to prescribed treatments.

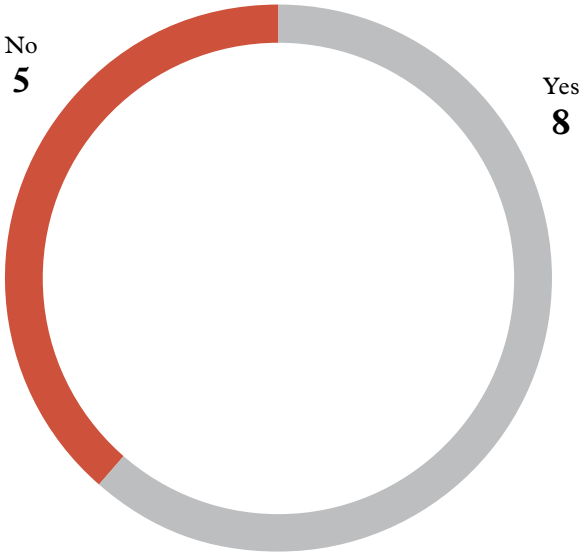
However, the cost control strategy requires a certain amount of clout, especially as hospital operators in several ASEAN countries have consolidated and/or are part of larger groups. Furthermore, the ability to control costs in the described ways is limited where insurers have to settle bills with hospitals within hours for the patient to be released. Due to these limitations, insurers often take a pre-emptive approach to cost control. For example, by defining a list of hospitals that they collaborate with and incentivising insureds to only use those providers. Furthermore, insurers may require pre-authorisation for elective procedures, such as the prior submission of hospital cost estimates or carrying out their own prior assessment of a hospital treatment. Insurers may also favour and cover outpatient treatments as a lower cost procedure than inpatient treatments.

Beyond these three strategies, insurers are working with policymakers, regulators and the hospital operator to improve market conditions, develop standards and raise awareness. Examples of this include initiatives such as the aforementioned introduction of a common database and the Diagnosis-Related Group (DRG) concept as a standard pricing tool, as well as the issuance of medical insurance guidelines whereby insurers explain the cause of rate increases (medical inflation) when policies renew to help motivate insureds to use health services more conscientiously. An additional example is the patient 10 % co-payment option initiative for inpatient treatments that was recently launched in Malaysia.

«Although Thailand's inflation rate is lower than many other ASEAN countries, it is also very important for local insurers to not only react to inflation, but to proactively address the issue. For example, insurers could proactively offer higher limits to customers to avoid underinsurance due to inflation. Or they could adjust pricing to reflect the rising cost of claims, which is already affecting motor insurance.»

Thomas Wilson, Country Manager, President & CEO, Allianz Ayudhya Assurance Pcl.

Are there any government incentives/initiatives to increase the take-up of health insurance among the low-income segment or general public? And if so, what are they?



The aim of ASEAN governments is to achieve the universal goals of equity, quality and financial protection in healthcare. As presented in the market overview section of this report, the approaches taken to achieve this aim widely differ – some lean towards a tax-funded system, as in Brunei and Thailand, while others have a strong private sector involvement.

Given rising healthcare costs, governments are keen to control, and where possible to reduce, their expenditure. However, as participants noted, an increased private sector involvement will only be viable if insurers can control claims costs. Expansion into low-income segments is particularly challenging in markets with high annual claims growth rates (estimations for some markets were close to 20%).

Governments are providing tax incentives in some markets to encourage consumers to take up private health insurance. Other initiatives by policymakers and regulators include facilitating micro-insurance in frontier markets and lowering barriers to entry (reducing capital requirements) for micro-health insurers.

As discussed in the previous question of this survey, cost control measures by policymakers and regulators also have the goal and potential to increase health insurance uptake: examples include the co-payment option in Malaysia, steps to develop a system of Diagnosis-Related Groups (DRG), and initiatives to build awareness amongst insureds of increasing healthcare costs by asking insurers to disclose the impact of claims inflation on rates in their renewal communications with insureds.

What is your main health insurance distribution channel?*

* Several choices possible

Overall, agents are the main distribution channel for ASEAN insurers. However, there is variation by product type – while agents are the main sales channel for private health insurance products, group health policies are mainly sold through brokers.

Insurers rarely directly sell health insurance. However, this is likely to change given the growing prevalence and importance of digital products that bring down costs and thereby open avenues to providing certain niche products directly to consumers, and possibly also to lower income segments.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