Global Asia
Insurance Partnership

Sustainable Private Health Insurance in Asia

Facing inflation and affordability concerns as we reduce protection gaps

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POLICY PAPER

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Executive Summary

Health protection gaps are a top priority as they are the most significant of all gaps in Asia. Key to closing this gap, health *financing* is critical. Health insurance is a growing and important source of protection for households and for funding the provision of health services for both current and potentially catastrophic exposures to individuals and households.

However, the financial sustainability of health insurance is being challenged. The main driver is medical cost inflation. High rates of medical cost inflation and increases in recent years have pushed the issue to the front of the agenda. Instead of being a manageable issue with a longer-term time horizon, it is now a short-term challenge that will become a full-on crisis if not addressed in the next two or three years. This now pushes it ahead of other common concerns, including the impact of demographic transitions, climate change, and social expectations.

Without collective action, undesirable consequences lie ahead. These outcomes are not in the interests of governments, insurers or citizens. Governments will face pressure from both their own fiscal exposures to provide basic health services, as well as significant concerns from citizens about affordability for their health costs. Private health insurance, that provides one key financing vehicle, risks negative spirals and market withdrawal.

Faced with these challenges, the following key principles and steps for action are recommended:

1. **Private sector insurance is an important contributor to health financing but can do more to grow the financing pool. Efforts that reduce this source of health financing should be avoided**. Instead, the goal is to grow the financing pool. Options can include:
    a. Reviewing the incentives for private health insurance;
    b. Examining opportunities for public education programs;
    c. Considering ways to increase the pool through group insurance;
    d. Considering compulsion for cover for temporary migrant workers where it does not already exist;
    e. Ensuring taxation systems do not disincentivise younger, healthier lives from taking out private insurance.
    f. Avoiding cost shifting.

2. **Affordability of health services is a unifying and critical imperative**. Currently, medical cost inflation is the most important challenge to affordability for consumers, fiscal challenges for governments, continuity for health delivery stakeholders, and financial sustainability for insurers. Partnerships are key to finding and operationalising solutions. Initiative can include:
    a. The relationship between health ministries and financial sector regulators needs to be a proactive partnership going beyond information exchange to a joint engagement, understanding challenges and developing solutions;
    b. From a unified government commitment, engagement with health insurers can reveal opportunities where the government can lead from the collection of data to minimum obligations on consumers.
    c. Health regulators have control, explicitly or through their leadership, to intervene in services and service delivery relevant for all stakeholders to secure the best results.
3. **For a sustainable health financing system, incentives need to be aligned for all stakeholders**.
    a. Coinsurance and deductibles for clients have a critical role, and they should not be reduced to levels where they have no effective impact. This may require government leadership when competitive pressures or regulatory constraints prevent individual insurers from acting.
    b. Medical providers can be engaged directly, and through schedules, cost agreed services, definitions of acceptable levels of service and treatment, to ensure incentives are aligned to broader goals.
    c. Preventative and healthy lifestyle engagement mechanisms make a positive contribution, whether it be in terms of direct claim costs, reduced customer lapsation, or simply increased engagement in health insurance by clients.
4. **Premium, renewal and other social constraints have to be very carefully managed**. They should reflect both social goals and balance financial stability. Ultimately, the protection from catastrophic costs needs to be a focus not unduly distracted by less core issues.
    a. Premium controls, especially when constraining increases, must be very carefully managed as it can undermine the stability of the insurance sector. Consultation, collaboration and the ultimate partnership that results from these deliberations is critical to both the health and insurance financial stability regulatory agencies.
    b. The same applies to product design constraints. Potential for product flexibility should be facilitated.

c. The potential for excessive exposure to high-risk clients needs to be managed subject to equalisation tools when there are premium controls on these clients and risks that limit actuarial fair pricing for risk. Relying on consistent levels of social engagement and solidarity alone may be problematic.

5. **Initiatives to reduce costs and improve service delivery can be advanced facilitating digitisation and other technologies including AI applications**.
    a. Reducing costs and improving service delivery at both insurers and health service providers will support efforts to partially offset pressures to pass medical cost inflation on to customers. However, **governments have to ensure that they do not have unnecessary or unintended regulatory barriers to adoption of sensible change.**
6. **Data is critical and may require government leadership to ensure adequate collection and dissemination.** Data includes that needed for policy development, sustainable and innovative insurance sector solutions, effective operation of larger medical service delivery agencies, and transparency to clients.
    a. Governments likely are the only actors who can ensure both public sector health data, private insurance data, and uninsured customer utilisation data is collected, collated and made available in a form that is helpful to foster innovation and develop financing solutions including insurance.
    b. Customer transparency on potential service costs greatly assists initiatives.

Introduction

Health, access to health services, and the financing of the costs of those services are critical priorities. For governments, health and wellness rank as obligations along with defence, law and order, social security, community resilience, sound economic management, and education. For people, health shocks and health treatments can bring together catastrophic life and financial consequences when not adequately addressed.

Health is a fundamental part of the Sustainable Development Goals. This includes the direct goal in SDG 3 "Ensuring healthy lives and promoting well-being at all ages" as well as the interactions between poverty, food security and nutrition, education, gender parity, sanitation and many other goals with health. Critical to health outcomes is health services and their delivery, and health delivery is fundamentally reliant on the financing of it.

In most jurisdictions, insurers are a critical partner as health insurance is a critical part of the health financing equation. And, as a consequence, insurance is a critical part of the achievement of the health delivery and health outcomes that society seeks.

However, both short- and longer-term conditions for health delivery are challenging. These challenges directly impact the sustainability of health insurance across Asia. Demand for and utilisation of health services reflect continuing social trends and the opportunity to take advantage of medical interventions, especially new and potentially more effective treatments from advances in medical science. The cost of new therapies is usually high, and advances in treatments often find more common use faster than prices benefit from economies of scale. This trend of medical cost inflation above general price inflation has been increasing across Asia.

At the same time, social and political pressure exists to avoid increases in contributions to public health funds, private insurance premiums, and cost sharing. The pressure of medical cost inflation runs into a counter-pressure of the societal reaction to increasingly burdensome cost increases. Adding the impact of ageing populations, changing climate risks, and pandemic experiences only magnifies the concerns.

For individuals and households, the cost of catastrophic health events represents a significant health financing challenge if they do not have adequate protection. Health insurance is fundamental to addressing these catastrophic exposures in many jurisdictions. Ongoing healthcare costs can also be significant, and health insurance can also provide a mechanism for more regular health expenditure management and encourage access to preventative care.

Recent trends across Asia highlight challenges in health service financing, including through health insurance. Contributions from governments through their direct budgets, from individuals and households through out-of-pocket costs, and through private health insurance, all face pressures. Fundamentally, these pressures come from increased costs that put pressure on the capacity to finance them.

Across Asia, medical cost inflation has exceeded general cost inflation at significant levels, especially in the last couple of years. At current levels, the challenges to financial sustainability for both government and private health financing have become far more immediate.

A problem with a 10-year time horizon to resolve is now closer to two years. In some countries it is a challenge "here and now". It is both urgent and more immediate than other challenges.

Short-term focused actions from some stakeholders can undermine the system for all. Sustainable solutions are critical. In the short term, ensuring that all parties can work together to respond to cost pressures is critical. The alternative, where stakeholders compete to constrain their own costs (and for private actors) to maximise their own potential income, can result in simply shifting burdens from one set of stakeholders to others. This behaviour may have short-term benefits for the relevant party, but quickly leads to the problem emerging again to a far larger extent. Many short-term solutions create secondary impacts that undermine the effectiveness of the very solutions themselves, especially the sustainability of the approach.

Responding to longer-term challenges relies on shorter-term issues being managed. In the longer term, structural changes such as demographic and climate transitions will exacerbate the challenges. Short-term solutions, when well executed, will not solve the longer-term challenges of themselves. However, without sufficient attention, the pressure of the shorter-term challenges will ensure that available attention for longer-term challenges is likely to be minimal.

This paper focuses on private health insurance challenges. It speaks to policymakers as they are critical to the way forward. It also considers the critical roles that both consumers and providers play as part of the mechanism that is healthcare financing. Our companion paper will look more completely at the interactions between all of these key groups from the perspective of the goals of broader healthcare delivery, organisational structures[1], and healthy outcomes.

Analysing challenges and potential solutions reflects a diversity across Asia whilst recognising shared challenges. Ultimately, the paper makes recommendations that are relevant to most jurisdictions in the region, whilst also allowing for local diverse systems to be reflected in how these recommendations might be implemented.

[1] Structural issues include fragmentation or concentration for all players in the health delivery and financing chain.

Health Protection Gaps in Asia – A Private Sector Lens

Protection gaps[2] are a persistent problem for individuals, households and nations. These gaps undermine resilience and sustainable development[3]. They create fiscal burdens on governments and expose economies to adverse shocks. Smaller gaps mean smaller problems, and greater resilience. Discussion often focuses on particular types of adverse events, or particular vulnerable groups and can be informed by the expertise of those having that discussion.

Considering protection gaps by magnitude, the "health protection gap" is the most significant in many countries and regions, including Asia. This reinforces the relevance of a "health imperative" that needs to be addressed. In fact, in Asia, the health protection gap is far larger than gaps relating to other concerns.

Health protection gaps are usually calculated by considering:

- *Out-of-pocket payments made (available from WHO statistics for most jurisdictions);*
- *Medical services foregone due to an inability to afford or access them, estimated through a range of data sources; and*
- *Adjusted for the stress of costs or foregone services, scaling them up or down.*

In addition, at GAIP, we consider the impact of additional shocks on governments such as responding to epidemics and pandemics, similar to what is applied to natural catastrophe gaps.

Health protection gaps are estimated using a number of metrics and have been published at the global and regional level and for some key countries. To further the capacity of each jurisdiction to advance its own efforts, we have provided preliminary estimates at a more granular level in Table 1 shown as a percentage of GDP and as an amount in $USD billions.

[2] Defined as the difference between economic losses from adversity and that covered by available resources including insurance.
[3] For a discussion on the impact of protection gaps on SDGs see GAIP (2025a), "Catalysing Resilience and Well-being: An Integrated and Holistic Approach to Protection Gaps", in particular the section on "motivation for action.." and the annex in the paper discussing key areas for each SDG.

Table 1: Health Protection Gaps –Jurisdictional Estimates[4]

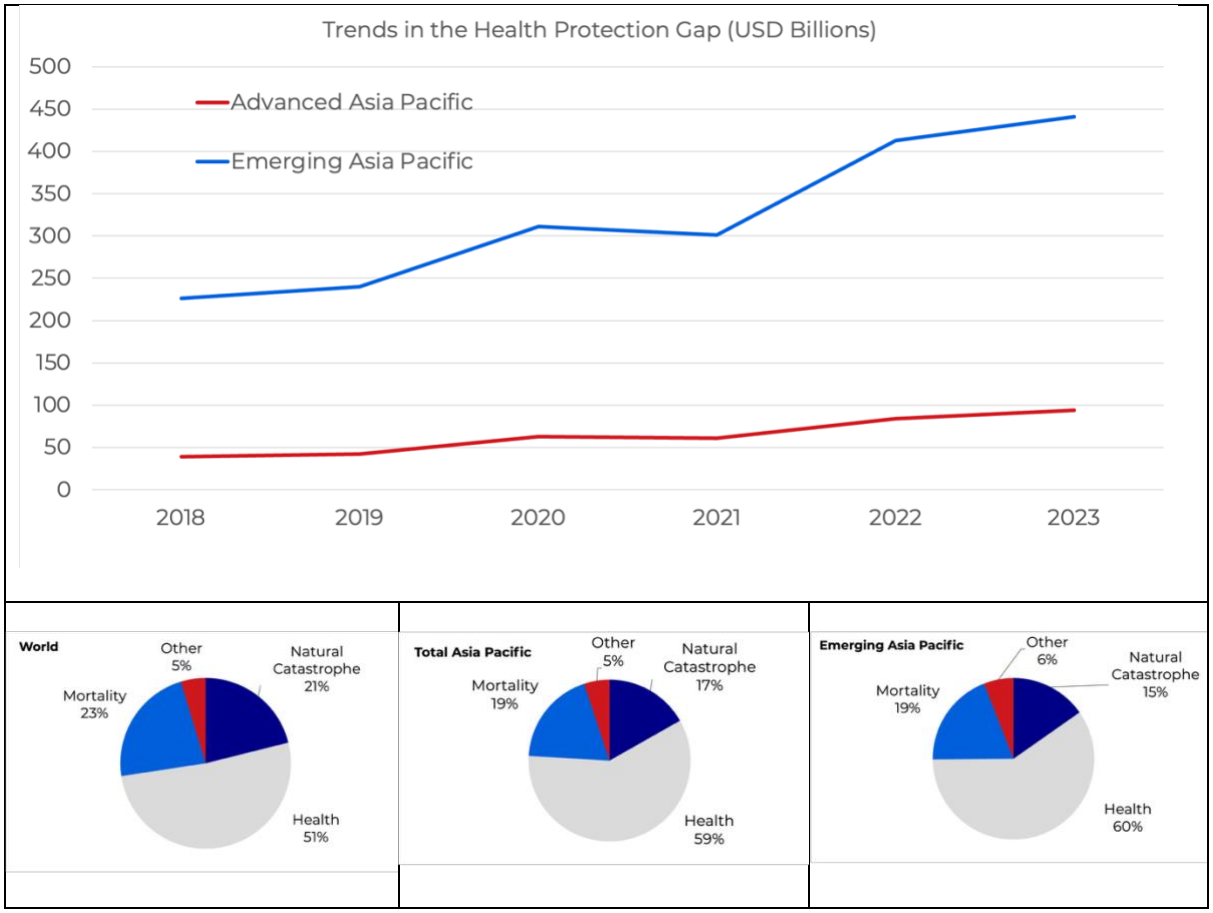
Jurisdiction	Percent of GDP	Billions USD (before Catastrophic Allowance)	Catastrophic Financing Allowance[5]	Total Annual Gap as Percent of GDP
Australia	0.36	6.05	0.37	0.73
Brunei	0.10	0.02	0.02	0.12
Cambodia	3.42	1.37	0.08	3.50
China	1.68	308.58	0.09	1.77
India	2.08	69.44	0.07	2.15
Indonesia	0.72	9.44	0.09	0.81
Japan	0.30	12.70	0.33	0.63
Laos	0.53	0.08	0.08	0.61
Malaysia	0.84	3.44	0.10	0.94
Myanmar	3.66	2.28	0.01	3.67
Philippines	2.28	9.24	0.05	2.33
Singapore	0.30	1.52	0.37	0.67
South Korea	1.71	28.54	0.09	1.80
Sri Lanka	1.78	1.32	0.02	1.80
Thailand	0.25	1.23	0.23	0.48
Viet Nam	1.53	6.31	0.03	1.56
Swiss Re Estimates				
Advanced Asia Pacific		**94**		
Emerging Asia		**441**		
World		**940**		

Source: WHO, World Bank, IMF, AXCO, Gallup Surveys, Swiss Re, and Author's analysis.

Compared to other perils, health gaps are the most significant across the region. Additionally, they have been expanding (see *Figure 1*).

[4] The most recent available data at the time this table was prepared was used for each element of our estimate. WHO data is for 2022. AXCO and Gallup data are used to determine relative scaling values in the overall formula, so the most recent data is applied to determine relative factors for each jurisdiction. Calculations were prepared in November 2025.
[5] Our methodology considers the experience of the Covid-19 pandemic reported by country by the IMF and uses "on budget" expenditure only. Figures will vary based on government's fiscal capacity to respond, social expectations, and other factors that vary considerably by country. For countries not identified, the reported median value was substituted. We have also assumed a conservative 1 in 50-year return period.

Figure 1: The significant health gap continues to increase



Source: Swiss Re

The total expenditure on health services and the way that they are financed varies considerably across Asia (see Table 2 below). Although the balance of various components of the health delivery system and the sources of finance can vary considerably, they consist of a set of parameters that includes financing from:

- Governments, financed through general taxation or defined health levies;
- Private health insurance[6] funded through premiums; and
- Contributions from patients through out-of-pocket costs.

[6] In this paper, the reference to Private Health Insurance refers primarily to the commonly recognised short-term products. It should also be recognised that some other life and non-life products contribute to health financing as they pay for medical costs as part of claims either directly or indirectly. They may include employer's liability, motor third party liability, personal accident and sickness products, and longer-term products such as critical illness and long-term care insurances.

For some countries, donor funding is also part of the financing mix.

Table 2: Health Financing Levels and Mix by Jurisdiction

Jurisdiction	Current Health Expenditure (CHE[7]) as % of GDP	Distribution of total CHE by source (percent)			
		Government	Private		Other
			Private Health[8]	Out-of-Pocket	
Australia	9.9	74.3	10.4	15.3	0.0
Brunei	1.8	92.1	0.0	7.9	0.0
Cambodia	4.4	26.4	3.3	61.0	9.3
China	5.9	57.7	10.6	31.6	0.1
Chinese Taipei	7.8	63.0	10.0	27.0	0.0
Hong Kong	8.3	51.8	13.5	34.7	0.0
India	3.4	40.4	13.9	44.5	1.2
Indonesia	2.7	51.8	14.3	33.0	1.0
Japan	12.3	86.0	2.8	11.2	0.0
Laos	2.0	31.0	4.0	28.7	36.3
Malaysia	3.9	50.6	11.5	37.9	0.0
Myanmar	4.5	11.1	10.7	65.1	13.1
Philippines	5.2	45.1	10.0	44.6	0.3
Singapore	4.3	60.1	16.4	23.5	0.0
South Korea	8.9	62.3	8.4	29.3	0.0
Sri Lanka	4.0	38.3	2.0	45.3	14.4
Thailand	5.4	72.7	18.0	9.2	0.1
Viet Nam	4.5	43.4	15.4	39.6	1.6
World	**8.6**				

Source: WHO (2022, the latest year available, accessed November 2025), Local data for Hong Kong and Chinese Taipei, Author's analysis

The relevance of health insurance as part of health financing in countries may be more or less of the total and may provide for benefits that are central to core health services or more "ancillary". Table 2 above also highlights the variation in the roles that private health insurance plays and the **potential for health insurance to play a greater role** in all jurisdictions, especially those where it is relatively less significant currently compared to the rest of Asia.

There is **variation in the operating environment for health insurance** as a result of structures and rules. Many jurisdictions have a public system that acts as the basis for providing health care for citizens and permanent residents. Membership is provided for all (compulsory) and is permanent.

[7] Note that CHE excludes capital expenditures such as for buildings and major equipment purchases and focusses on current goods and services.
[8] This item is calculated by the authors as the total private health financing less the out-of-pocket costs (that do not include health premiums) to identify private expenditure focused on private sector provisioning of finance.

Private health insurance usually plays an ancillary role to the “core” public system. It can provide:

- **Purely supplemental benefits**: additional benefits such as optical, dental and pharmaceutical services that are not covered by the public scheme;
- **Enhanced benefits**: providing additional funds for services that are covered by the public scheme but to facilitate a more immediate access to care where there would otherwise be waiting periods, or enhanced services such as upgraded accommodation in hospitals, or to reduce out-of-pocket costs on claims under the public scheme;
- **Or both.**

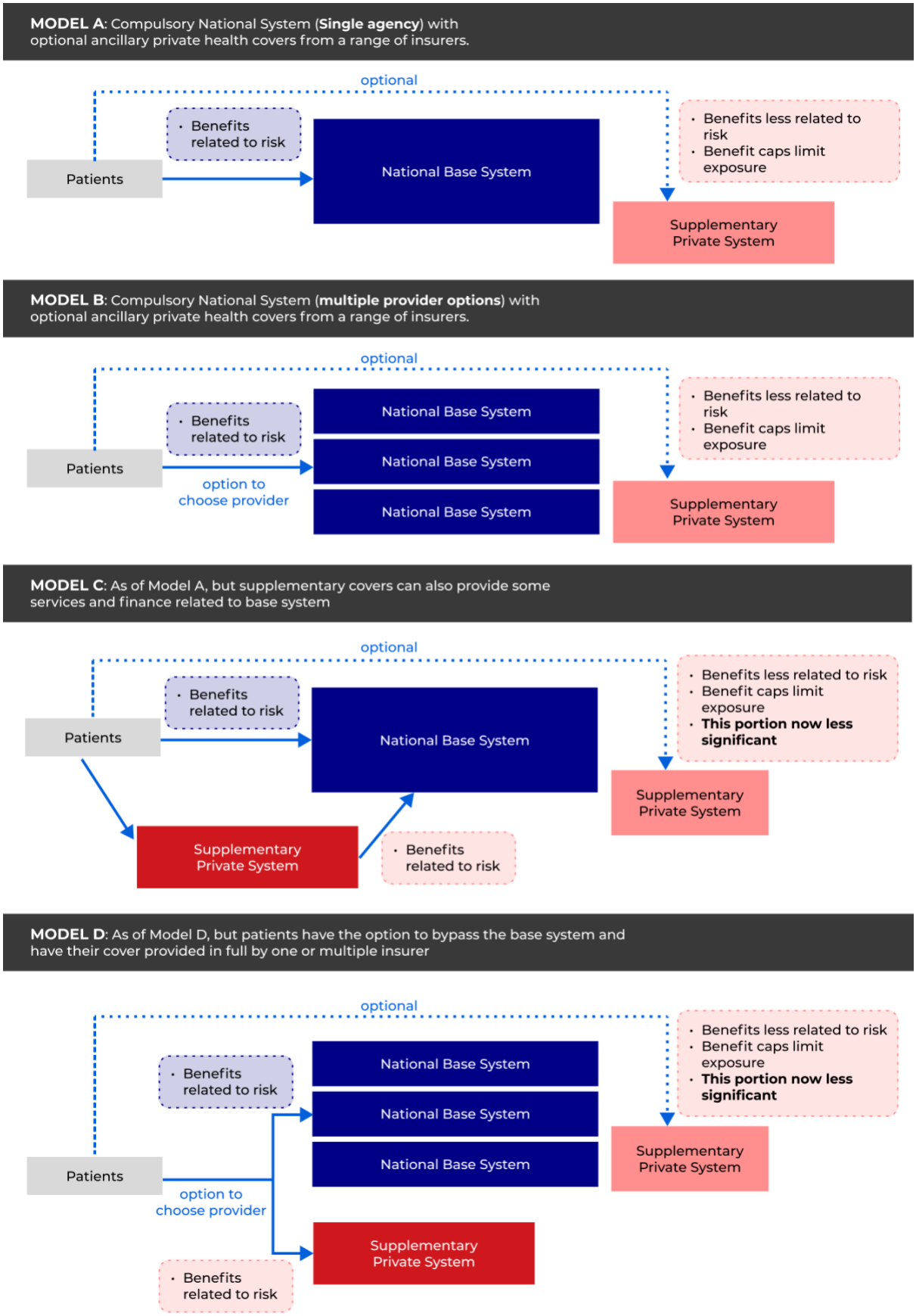
This blend is important as, in the case of enhanced benefits, the claims are shared between the public scheme and the private insurance, and the two sectors are exposed to the same frequency of claims for the shared events. When health insurance is focused on supplemental benefits, it focuses on different claims with different frequencies and payments. In the supplemental case, exposure to excessive risk for insurers is controlled through limits on benefits. Enhanced benefits, on the other hand, are more difficult to limit in frequency as they are driven by the benefit structure of the public scheme.

In some jurisdictions, private health insurers may be subject to additional rules that impact their risk including:

- Whether or not, and in what circumstances, they may accept or decline a proposal for insurance;
- Whether or not they have to offer renewal of existing insurance policies; and
- The potential for changes in premiums for new business and/or on renewal may be subject to constraints or regulatory approval.

Additionally, it is possible in some systems for a policyholder to opt out of the public scheme and, instead, seek the full benefits and coverage from a private insurer, as shown in model D of Figure 2.

Figure 2: Illustrations of Structures for Health Financing



The United Nations Sustainable Development Goals (SDGs) include health indicators. These are reported in the annex to this paper. Figure 3 shows the part of the index that considers the capacity of the health system and access to it. As can be seen, there is considerable variation between countries, and several countries have seen substantial improvement over time, consistent with improved access. The World Health Organisation (WHO) reports considerable data in support of both the SDG indicators and other metrics.

Figure 3: Service Coverage Index – Capacity and Access

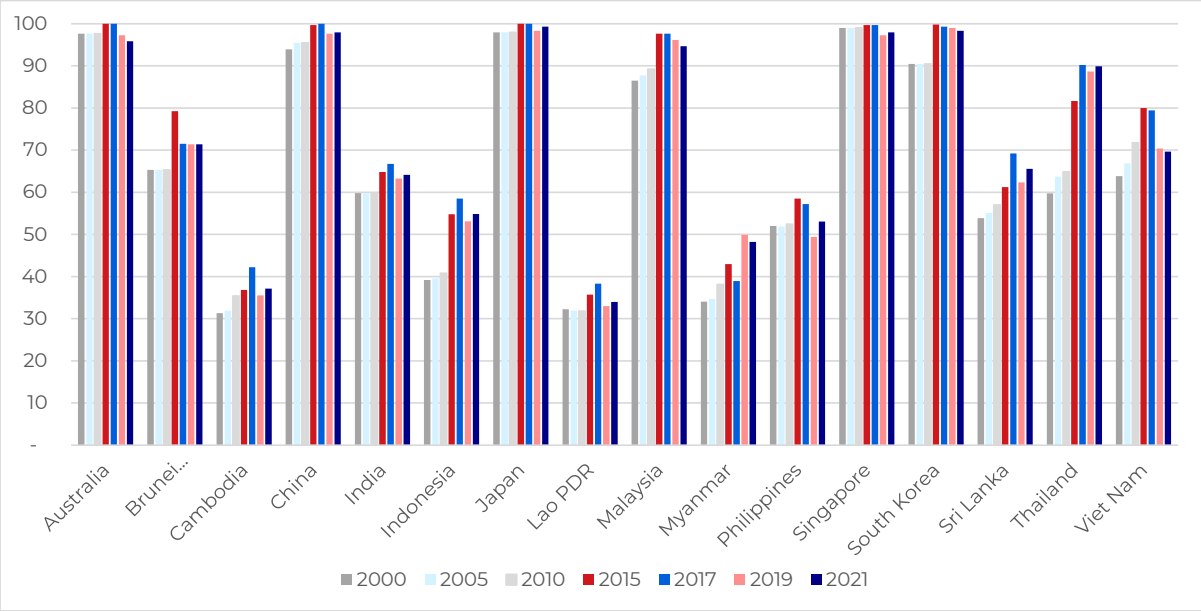


Table 3: Examples of Statistics on medical infrastructure by jurisdiction

	Doctors per 10,000 population	Hospital Beds per 10,000 population
Australia	42.28	38.2
Brunei	21.79	35.8
Cambodia	2.11	7.3
China	28.19	56.3
Chinese Taipei	21.7	73
Hong Kong	21	49
India	9.55	15.9
Indonesia	5.59	13.7
Japan	26.49	125.9
Laos	3.77	17.1
Malaysia	22.72	19.6
Myanmar	7.57	10.7
Philippines	8.69	9.7
Singapore	26.70	28.1
South Korea	26.63	128.1
Sri Lanka	11.36	39.3
Thailand	5.91	23.9
Viet Nam	11.07	25.2

Source: WHO, other sources for Hong Kong and Chinese Taipei. Latest year available at time of publication.

Medical Cost Inflation: The challenge that starts it all

Although there may be many potential sources of challenges for health financing, the most fundamental and evident issue is medical cost inflation. Without a solution, any system of structuring and financing health services will be vulnerable to crisis.

Medical insurances have always been vulnerable to claims cost inflation. It is long understood that many types of insurance can be subject to claims cost inflation that exceeds broader price inflation and inflation in medical prices. "Superimposed" inflation can be magnified by changing community expectations and norms. Increased utilisation of health services can come from changed expectations and lead to increased costs. Total health costs can also increase as access and utilisation increase (as is evident in Figure 3 above). Costs can also expand due to the impact of the rollout of new breakthrough discoveries that are costly but quickly become part of expected treatments.

Claims cost increases can also result from increased incidence of illness. Climate-related changes are one cause of increased incidence of illness from a range of factors such as heat stress, increased pollution, and the impact of natural hazards. In the longer run, demographic ageing also means that medical interventions will be more frequent, given that older people, even when in good health, tend to use medical services more than their younger generations.

Asia has seen its share of medical cost inflation in recent years, impacting both health protection gaps and the sustainability of health financing. The levels of medical cost inflation can be estimated and have been reported in Table 4 below. These rates show medical trend rates published regularly by Aon, and primarily are an indicator of cost pressures in private health financing, especially as reflected in employer-sponsored medical plans. The table shows inflation in excess of general price inflation ("net")[9]. Most recently, with one exception in the table, medical cost inflation has been increasing. Table 4 highlights that the increases in 2025 have been materially higher in some cases, indicating an acceleration. Rates have reached very high levels in excess of 10% (after general price inflation!) in many jurisdictions.

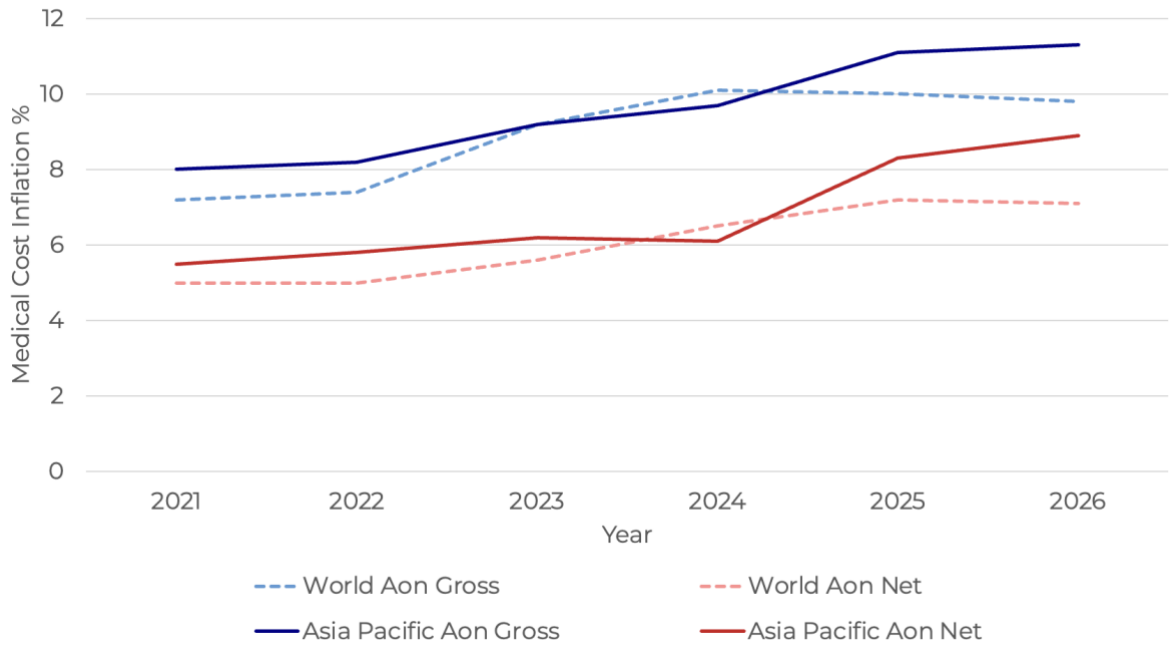
[9] Both "gross" and "net" values are shown in the Annex.

Table 4: Medical Cost Inflation has been increasing across Asia

Jurisdiction	Medical Claims Inflation in excess of general price inflation Percent				
	2021	2022	2023	2024	2025
Australia	0.7	1.5	1.0	1.0	2.1
China	4.4	5.1	5.7	5.7	6.0
Chinese Taipei	6.5	6.8	7.8	8.3	n/a
Hong Kong	2.8	3.7	4.9	5.1	5.7
India	5.4	8.9	7.2	7.6	8.8
Indonesia	10.1	9.1	9.4	10.1	13.6
Japan	(0.4)	(0.7)	(0.4)	(1.8)	(1.2)
Malaysia	11.2	10.0	12.6	11.9	12.5
Philippines	5.1	5.0	5.3	10.8	12.0
Singapore	6.5	6.2	10.0	9.5	11.5
South Korea	7.1	7.1	5.1	7.7	8.0
Thailand	6.0	10.7	9.5	7.1	13.1
Viet Nam	4.8	1.6	3.3	2.4	9.5
ALL ASIA	**5.5**	**5.8**	**6.2**	**6.1**	**8.3**
World	**5.0**	**5.0**	**5.6**	**6.5**	**7.2**

Source: Global Medical Trend Rates Reports (AON), where jurisdictions are not shown then they are not reported in the source data.

Figure 4: Asian medical cost inflation is outpacing global trends and reaching problematic levels across the region.



Source: Aon and Authors analysis

Another measure is **the rate of change in total Current Health Expenditure (CHE) as a percentage of GDP**. This measure isolates medical cost inflation compared to the real growth in the economy (a rate higher than price inflation in the long run), so it presents lower rates of change but adds to the data picture and confirms that many countries have seen an uptick in medical cost inflation in the last 5 years compared to earlier periods.

Table 5: Medical Cost Inflation measured by CHE – real rate of change compared to GDP growth

Jurisdiction	Average Annual Percentage increase in Medical Claims in excess of Gross Domestic Product		
	Since 2000	Last 10 years 2013-2022	Last 5 years 2018-2022
Australia	1.23	1.37	-0.36
Brunei	-1.52	-0.16	-4.32
Cambodia	-1.44	-1.92	1.98
China	0.80	1.63	1.16
Chinese Taipei	1.66	1.82	1.85
Hong Kong	3.62	6.52	9.76
India	-0.98	-0.06	2.40
Indonesia	1.72	-0.78	-1.49
Japan	2.23	0.68	1.39
Laos	-3.36	-0.29	-4.40
Malaysia	2.04	1.23	1.06
Myanmar	4.14	7.26	0.47
Philippines	2.40	2.13	5.44
Singapore	1.76	3.97	2.55
South Korea	4.14	4.32	5.99
Sri Lanka	0.27	2.79	5.54
Thailand	2.51	4.28	6.80
Viet Nam	0.50	-0.85	-1.66

Source: WHO, Jurisdictional data sources for Chinese Taipei and Hong Kong, Author's calculations

Both measures above consider increases in medical costs, encompassing medical price increases, as well as the various impacts of increased utilisation, higher illness incidence, changes in treatment mixes and technology, etc., as discussed above.

It is also possible to examine medical price inflation. Medical price inflation is based on the Consumer Price Index (CPI) Health / Medical Care component published by national statistical agencies, and classifications differs by jurisdiction; in some cases (e.g. Singapore) the Health CPI includes health insurance premiums, while in others (e.g. Australia, Malaysia) health insurance premiums are captured under a separate Insurance/Financial Services CPI group. Despite these differences, it is still worthwhile to cross-examine them with the figures in Table 4 and Table 5 above.

The medical cost inflation measures in Tables 4 and 5 reflect changes in total medical expenditure or medical plan costs, incorporating not only price changes but also shifts in utilisation, treatment intensity, technology adoption, and disease incidence. By contrast, Table 6 shows Consumer Price Index (CPI)-based medical price inflation, which tracks consumer-facing price changes for defined baskets of health-related goods and services and is measured from the perspective of household consumption rather than insurer- or system-level expenditure. Differences in coverage, weighting, and institutional settings across jurisdictions further limit direct numerical comparison between these tables.

Nevertheless, viewing these indicators side by side remains analytically valuable, provided their conceptual differences are respected.

Table 6: Medical Price Inflation published as a component of overall price increases

Jurisdiction	Medical Price Inflation, Percent				
	2021	2022	2023	2024	2025
Australia	3.3	3.8	5.1	4.0	4.2
Brunei	0.1	0.2	0.0	0.1	n/a
China	0.8	0.8	1.1	1.3	n/a
Chinese Taipei	0.3	1.5	2.8	2.5	1.9
Hong Kong	1.7	0.8	4.0	4.6	1.8
India	7.1	6.2	5.1	4.1	3.9
Indonesia	1.8	3.2	2.2	1.9	2.1
Japan	(0.4)	(0.3)	1.9	1.6	0.8
Malaysia	0.4	2.2	2.2	1.8	1.5
Philippines	3.7	2.9	4.5	3.4	3.3
Singapore	1.1	2.2	4.5	3.9	2.3
South Korea	0.3	1.4	1.8	1.9	1.1
Thailand	0.2	1.1	1.6	0.1	n/a
Viet Nam	0.2	0.4	0.6	2.5 – 3.5	12.7

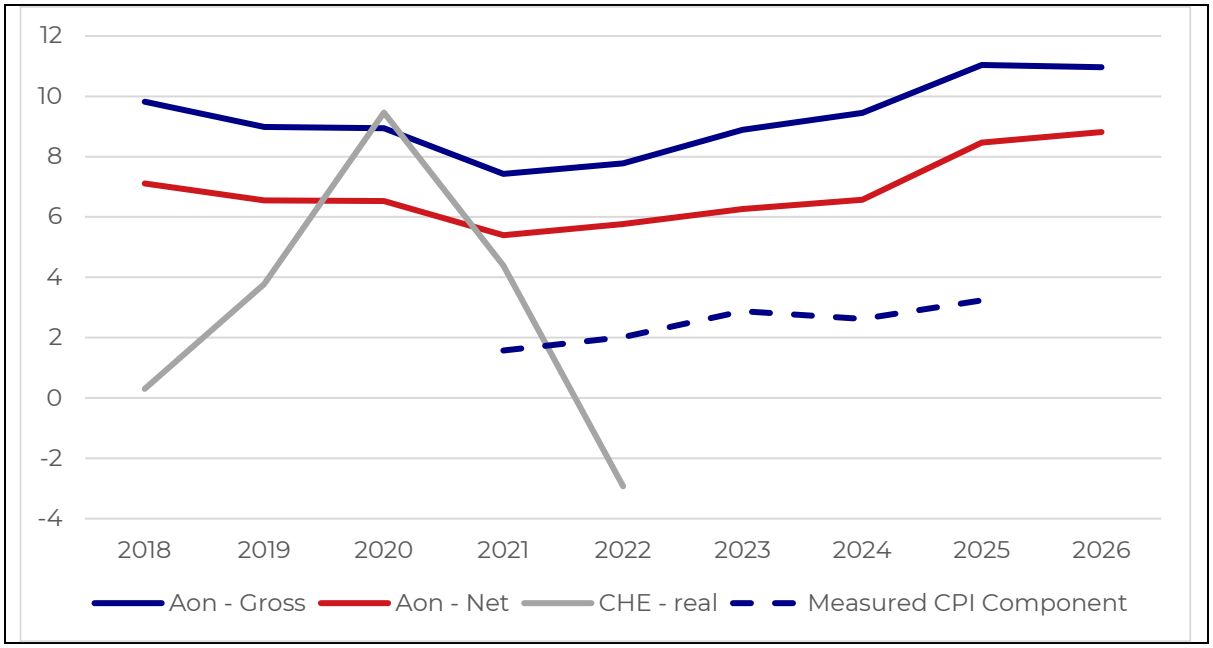
Source: Jurisdictional Statistical Agencies, Author's analysis

CPI-based medical price inflation indicates the underlying price environment faced by households and, indirectly, by payers. Across many Asian jurisdictions, price measures have generally remained more moderate and less volatile than the observed claims-based medical cost inflation. While price pressures are evident in specific categories, they do not, on their own, account for the magnitude or acceleration of medical cost inflation highlighted earlier.

Tables 4 through 6 should be read as complementary, not comparable, lenses on the same challenge. Medical price inflation frames the baseline price environment, while medical cost inflation reflects the full impact of prices interacting with utilisation and system design. Taken together, the evidence indicates that while medical prices matter, recent medical cost inflation across Asia is increasingly driven by utilisation intensity, treatment mix, and system design rather than price growth alone.

On all measures, medical cost inflation is increasing in recent years and is increasingly problematic. *Figure 5* shows the increasing trend regardless of whether the measure is within or over and above CPI. Comparisons to GDP also suggest positive excess inflation although data is less clear as the most recent years from the WHO are impacted by pandemic responses.

Figure 5: Medical Inflation on various measures for all jurisdictions of interest with all data items



More granular data at a jurisdictional level on inflation in medical costs is in the annex at "Medical Inflation – Gross and Net" starting at page 66.

The data clearly suggests that policy responses focused solely on price containment on a service by service or "unit cost" basis are unlikely to restore sustainability. Without addressing utilisation incentives, care pathways, benefit design, and provider–patient decision-making, price-based interventions risk shifting costs, suppressing access, or destabilising financing arrangements rather than resolving underlying pressures.

Medical cost inflation pressures the system and its participants

Medical cost inflation puts pressure on the system and its participants. Key players face difficult choices. Ultimately, the goals of various stakeholders come down to adequate financing for health services, affordability for consumers, and financial stability for private sector providers, including insurers and reinsurers.

Table 7: Analysis of Potential Problematic Stakeholder Responses to Medical Cost Inflation

Stakeholder	The impact of medical cost inflation	Undesirable Outcomes	Desirable Outcomes
Consumers	Increases in health costs challenge **affordability**. As other stakeholders respond to their own pressures, there is increasing potential for this burden to be passed to consumers (rather than shared with them) exacerbating the challenge of **unaffordable** health challenges.	Participating in prefunding health financing through a combination of national and private health insurance becomes **unaffordable**. Consumers then reduce their commitment to health financing to the minimum, except (although perhaps even) when they are certainly in high-risk groups with existing conditions. This increases the health protection gap and the exposure of individuals to catastrophic health cost risks. It also increases the risk profile of the remaining insured pool.	Access to health services, particularly for catastrophic costs, consumers need access to affordable health insurance. Health financing needs are better met through reduced health protection gaps. Information about costs and alternatives is available and informative and can be used to manage health costs where possible.
Health Insurers	**The principal focus of this paper**, insurers have little choice when confronted with medical cost inflation. They can increase premiums, reduce benefits, improve expense efficiency, or a combination of these options. We discuss this in more detail in the next section. Here we observe that the higher the levels of medical cost inflation the less likely that expense reductions would, no matter how meritorious,	If unable to ensure **financial stability** of the business line, there will be pressure to exit the market. If able to increase prices, however, this will pressure customers at renewal. Healthier clients may question the value of this insurance and drop the expense leaving a less healthy pool and pressuring for more price increases – a **downward spiral** that ultimately also leads to market withdrawal.	Health insurance is a viable and sustainable product.

Stakeholder	The impact of medical cost inflation	Undesirable Outcomes	Desirable Outcomes
	make a material contribution. For individual insurances in a competitive environment, increases in premiums are difficult, and reductions in benefits will also be problematic; either way, they would be shifting the burden of medical cost inflation from the insurer to the customer.	The **total health financing pool suffers** as a result of this potential outcome.	
Employers	For group insurances, employers will have a view on the balance between reducing benefits and increasing premiums. Generally, they want to see premium increases constrained, increasing potential out of pocket costs for employees. As an alternative, they may shift away from providing this benefit to employees at all, instead, providing a fixed amount and encouraging employees to make their own arrangements.	This shifts costs progressively to employees exacerbating a crisis of affordability.	Employee benefits support ongoing business needs, employee retention, and recruitment.
Health providers – Direct service providers	Although their main motivation may be maximising income, pressures of affordability on clients and financing from government and intermediaries can constrain their situation. They will be under pressure to pursue efficiencies in delivery from both shareholders and health service financing providers.	Under pressure to reduce costs, waiting lists and services levels may fall to unacceptable levels, creating public concern. Increased pressure may also lead to service level reductions and potential catastrophic outcomes for some patients.	Adequate patient care is the primary goal and is not impeded by financial considerations for providers or their patients.

Stakeholder	The impact of medical cost inflation	Undesirable Outcomes	Desirable Outcomes
	At the same time, new services and treatments are consistent with their objective to secure the best health care for their customers. So, they need to deliver basic services more effectively whilst providing for better services as much as they can, even when they do not benefit directly.		
Health providers – New initiative providers	Providers of new services and treatments are largely insulated from medical cost inflation impacts on many stakeholders as they deal through the front-line service provider. As a result, they promote and encourage increases in services and costs.	Providers may promote services aggressively and increase social expectations for more immediate service delivery, in particular, creating incentives that exacerbate the challenges further.	Innovations can be delivered to patients that need them consistent with long term sustainable goals.
Governments – fiscal focus	**Medical cost inflation is a problem for public services as much as it is for private services**. As a result, fiscal constraints will exert constant pressure as medical cost inflation rises.	Cost shifting by reducing benefits in the public system may increase benefits payable by the private system. This shifts the medical cost inflation impact from the public sector but only as far as the private sector where it may be magnified substantially[10]. The consequences would be to bring forward the negative impacts of private provider departures.	Medical costs can be adequately financed within fiscal frameworks.

[10] For example, when the private sector is 15% of total financing and the public sector is 45% (both conservative but refer Table 2 on page 10 for regional data) then the impact of a cost shift of 5% medical cost inflation could be a 15% increase in premiums unless there is a further transfer to consumers in out-of-pocket costs.

Governments – Political focus	Medical services and medical insurance become increasingly unaffordable for voters, creating a movement for action.	**Policies that constrain the capacity of insurers to pass on true costs to customers erode their financial stability.** Temporary solutions may be saleable, but longer-term constraints will deliver market departure and reduced confidence in one funding stream.	Public concern about availability and cost of health services and insurance is low.
Governments – Economic or Social focus	Social contracts may suggest that benefits must remain affordable and available. Cost inflation challenges this balance. As health care costs continue to increase, available savings are eroded, risk taking is avoided and economic growth is less than otherwise.	Social pressures lead to direct intervention to constrain cost increases to an extent that can undermine insurer stability.	Benefits are provided within acceptable social expectations and consistent with economic needs.
Governments – service providers	Government services remain in high demand and, in the absence of additional financing, will lead to longer wait times and a rationing of services.	Public health delivery constraints can lead to pressures on staff and infrastructure at unacceptable levels for both health professionals and eroded service delivery for consumers.	Public sector health delivery is adequately financed, available and accessible, achieves acceptable outcomes, and is well regarded.

As claim costs increase, health insurance can only remain sustainable if premiums increase consistently with the claims. These increases can be difficult in markets where regulatory limits on prices apply, supervisory approval decisions constrain pricing decisions, or where markets are particularly competitive. Even if price increases could be accommodated, the impact of increased medical cost inflation on premiums would mean that they would become increasingly unaffordable for many households.

In most jurisdictions, where medical cost inflation has been high, claims ratios are high and the products struggle for profitability. Selected ratios are shown in Table 8 based on a range of available sources. A combined ratio above 100% or a claims ratio above 80% usually reflects problematic profitability. In markets that are still developing, expense rates tend to be higher, and claims ratios above 70% could be problematic. Several jurisdictions are in that range and facing challenges.

Table 8: Examples of Claims and Combined Ratios in selected jurisdictions

Jurisdiction	All Products that provide some medical coverage				Personal Accident and Health			
	Claims Ratio		Combined Ratio		Claims Ratio		Combined Ratio	
	Current	5 years earlier	Current	5 years earlier	Current	5 years earlier	Current	5 years earlier
Australia	75.65	82.25	75.11	84.06	84.25	86.09		
Cambodia	50.01	40.10			50.01	40.10		
China	59.67	38.39			59.67	38.84		
Chinese Taipei	45.43	47.20			45.43	39.84		
Hong Kong	48.16	38.12	78.04	69.57	77.00	69.42	103.55	95.20
India	71.22	75.98	81.36	78.91	71.22	75.98	81.36	78.91
Indonesia	86.45	77.13	109.04	93.69	86.45	77.13	109.04	93.69
Philippines	80.71	43.35			80.71	36.54		
Singapore	50.16	57.37			50.86	53.20		
South Korea	73.91	83.48			72.08	71.77		
Sri Lanka	86.09	110.60			86.09	110.60		
Thailand	44.24	40.23			38.81	33.76		

Source: AXCO, most recent year at time of writing. Note: Some values for claims ratios and combined ratios are for different years for a jurisdiction. Where jurisdictions are not shown the data was not available in the AXCO data set.

How long do we have to act?

As noted, several jurisdictions are feeling the impact of the medical cost inflation crisis. But, at current levels, others can be expected to find themselves in the same situation soon unless action is taken while there is still time. Key determinants of the extent of concern lie firstly in the levels of expected medical cost inflation (as noted in Table 4), secondly on the relevance and desire for an element of financing of the health system from private health insurance (such as the health protection gap shown in Table 1), and thirdly, the size of the contribution currently being made (see Table 2).

On global averages, it would take 8 years of inaction before a crisis hit. But with the levels of medical cost inflation evident in Asia, this is reduced to 7 years if we assume the average rate of increase. If we consider some of the higher levels observed in the region, this could reduce to 4.5 years, making this the key issue to address before all others.

The world average CHE is 5.75% and the average medical cost inflation over general price inflation is 7.2%. If allowances for general price inflation were maintained, GDP was limited, and no other financing adjustments were made then it would take just under 8 years for CHE to reach 10% on average. If the same calculation were made at the higher current Asian average rate of 8.3%, a full year of potential opportunity will be lost, and the result reduces to under 7 years. At some of the current rates observed in Asia, a 10% inflation would reduce the time available to 5.8 years

and 13% inflation brings it back to four and a half years. At these levels, medical cost inflation is the most pressing of all challenges as surviving these issues is paramount before addressing the other issues no matter how critical.

Table 9 further highlights the challenges using two scenarios. If medical cost inflation can be reduced to 5% per annum, then the time available for further adjustment extends to just under six and a half years. Absorbing inflation above general price levels can create its own crisis in as little as two years. Increasing premiums at required levels will pass on very high price increases to consumers, defying expectations of ongoing affordability. Neither extreme is likely to be acceptable or practical. Even a jurisdiction with a lower claims ratio but high medical cost inflation is not immune from this shortening time horizon for action.

Table 9: Illustrations of the Urgency of Practical Challenges

Scenario		Time to reach a 75% claims ratio if premiums are constrained to broader price inflation?	% increase in premiums above price inflation to maintain claims ratio over the next 3 years?
1	The world average CHE is 5.75%. With medical cost inflation of 5% over price inflation. The average claims ratio assumed is 55% (conservatively)	6.4 years	15.8%
2	The world average CHE is 5.75% and the average medical cost inflation over inflation is 7.2%. The average claims ratio assumed is 55% (conservatively)	4.5 years	23.2%
3	The Asia Representative Average Case: Claims ratios at 60% and the Asia average 8.3% inflation.	2.8 years	27.0%
4	A 60% claims ratio but with higher observed medical cost inflation at 10%	2.3 years	33.1%
5	Claims ratios at 45% but facing medical cost inflation of 13%	4.2 years	44.3%

Table 9 illustrates how sustained medical cost inflation places pressure on the financial sustainability for private health insurance and affordability for citizens. Whilst the time will vary by jurisdictions depending on experience, benefit structures and pricing flexibility, **one message is clear – when medical cost inflation persistently exceeds price inflation, the time available for adjustment narrows, urgency to act becomes more critical, and flexibility to find solutions is more constrained**. What might have been a challenge of lower consideration has, because of higher inflation, jumped to the front of the line in many countries in the region.

Without sustained focus on measures that align stakeholders, including governments and insurers and policyholders as well as health providers, then the challenges will remain and the time to address them will continue to reduce. Action, be it about utilisation patterns, benefit design, incentives or other aspects, are required and adjustments will likely become increasingly more difficult and more disruptive if delayed.

As if that isn't enough, other key risks and pressures

Financial stability for health insurers is challenged by medical cost inflation but, even if it were not a pressing issue, other considerations are important. This section discusses these key issues.

Adverse Selection

Health insurance is exposed to adverse selection[11] but the usual options to control such exposures may be constrained. Regulations may include:

- Obliging insurers to accept rather than decline risks;
- Limitations on exclusions, waiting periods, benefit limits, or other policy wording controls;
- Limitations on applying full actuarially fair prices to higher risks.

Even without regulation, market competition can lead to some practical constraints along similar lines. In such situations, it may be difficult for one insurer to lead the market back to more sustainable practices.

The extent to which insurers are exposed to adverse selection can be reduced when the volume of healthier lives insured is sufficient to balance the risk pool. The structure of the system will be a key driver to this outcome (refer to Figure 2 for examples). Additionally, the existence of employer-arranged group insurances can also be positive as it ensures more healthy lives are automatically included. Governments can also influence the extent that healthier lives participate in private health insurance through their regulatory policies.

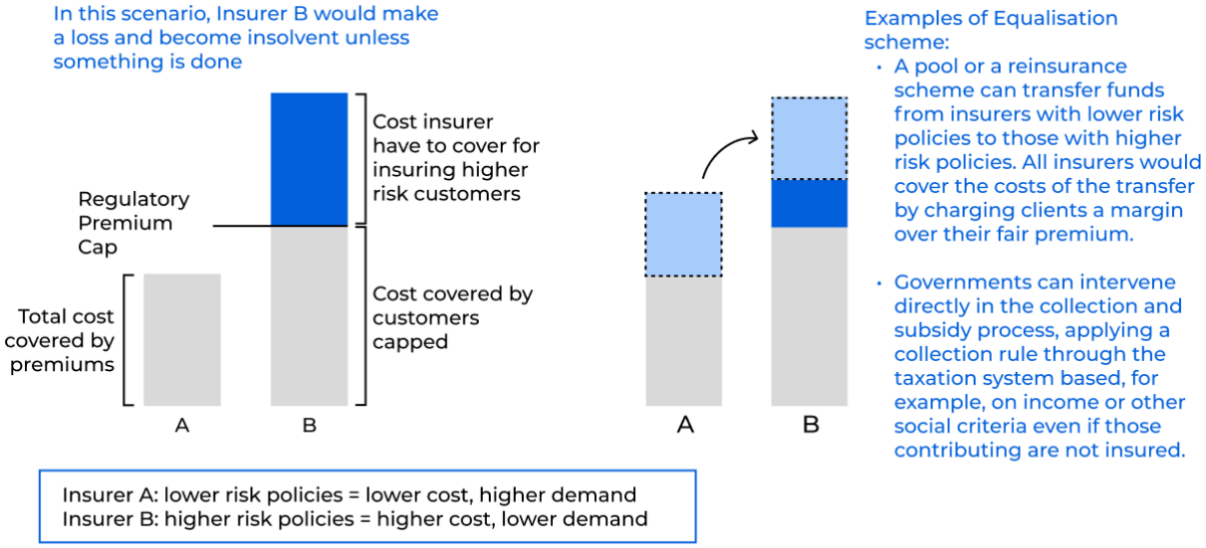
If acceptance of customers, the premiums charged, and the benefits that are provided to them in private insurance are constrained, then this introduces two particular risks.

1. Adverse cycles: When an insurer reacts to a deteriorating risk profile, this can encourage better risks to leave and further exacerbate the deterioration.
2. Risk concentration: When customers can select their insurer, there is a risk that one or other insurer will have a disproportionate share of the higher risk clients.

[11] Adverse selection is the risk that higher risk customers are more likely to take out insurance than lower risk customers because they have more information about their own risk profile.

One additional element that may be required when customers can select their insurer and there is a risk that a higher proportion of adverse risks will end up with one insurer, or high-risk customers have some premium protection, is to have some system of equalisation. This involves the transfer of contributions from healthier participants to cover the shortfall in contributions made by high-risk clients at a "system wide" level. Figure 6 provides an illustration of how such schemes operate. They may be structured through the base government system or, alternatively, through a risk pool, government revenue collection and subsidy arrangement, or even a reinsurance system.

Figure 6: Equalisation Scheme Examples



Demographic change

Medical cost inflation has been impacted by demographic change, but expected future changes are a source of significant concern as populations age. It is widely acknowledged that the costs of healthcare for older people tend to be higher than for younger people. There are two main schools of thought regarding these costs: first, that older people use health services more frequently, and the second alternative is that these costs are driven by high expenses in the later years of life. Either way, the observed costs for older people as a group are higher. The difference is only a question of the incidence of these costs.

Demographic change, therefore, often focuses on the proportion of older people. Additionally, the composition of the population as a whole is relevant, especially the working age group. The ratio of older people to working age people, the age dependency

ratio, highlights the number of older people in society that each working person, it implies, is supporting.

Table 10: Indicators of Demographic Aging in selected jurisdictions

Jurisdiction	Percentage of the Population in each group				Age Dependency Ratio (15-64 / 65+)		Population declines	
	Current		10 years ago		Current	10 years ago	Total	15-64
	15 - 64	Over 65	15 - 64	Over 65				
Australia	64.6	17.4	66.7	14.4	3.7	4.6	No	No
Brunei	72.5	6.5	71.8	3.8	11.1	19.1	No	No
Cambodia	63.9	6.0	63.5	4.3	10.7	14.9	No	No
China	69.1	14.3	72.3	9.4	4.8	7.7	No	Yes
Chinese Taipei	69.7	18.3	74.4	11.4	3.8	6.5	Yes	Yes
Hong Kong	67.7	21.7	74.1	14.3	3.1	5.2	No	Yes
India	68.0	6.9	64.9	5.2	9.8	12.5	No	No
Indonesia	68.0	7.1	66.7	6.0	9.7	11.1	No	No
Japan	58.8	29.6	61.5	25.4	2.0	2.4	Yes	Yes
Laos	64.9	4.5	61.7	4.0	14.3	15.3	No	No
Malaysia	70.3	7.5	68.1	5.4	9.4	12.6	No	No
Myanmar	68.4	7.1	67.5	5.4	9.7	12.5	No	No
Philippines	66.1	5.3	62.0	3.5	12.6	17.7	No	No
Singapore	75.1	13.1	78.7	8.2	5.7	9.6	No	No
South Korea	70.7	18.3	73.2	12.1	3.9	6.1	No	Yes
Sri Lanka	65.9	11.7	66.7	8.3	5.6	8.0	No	No
Thailand	70.2	14.7	71.7	9.5	4.8	7.5	No	No
Viet Nam	67.8	8.6	69.9	6.2	7.9	11.3	No	No

Source: United Nations, population division data, Author's analysis.

The values in Table 10 are in the form that is often cited as a summary indicator, and each jurisdiction sees evidence of ageing populations over the decade. However, they can hide several important elements. The age ranges, although standardised for comparative purposes, may not reflect actual working age and retirement periods, especially due to changes in participation in tertiary education, more flexible transition arrangements from full employment to part time work before full retirement, and initiatives for healthy ageing. Notably, most jurisdictions see an ageing population, but still have growing populations and workforce age groups. For those jurisdictions where the population is ageing and the workforce is shrinking, the situation is more stark.

In addition to ageing, the demographic impacts on health include the direct impact of increased life expectancy on the health needs of older people, rural to urban migration often leading to a change in access to and use of health services, changes in workforce participation especially when formal workers may potentially get access to health

insurance through group arrangements, and international migration that also influences workforce composition, delivery of services, and fiscal balances.

In most jurisdictions in Asia, these additional demographic influences offer the potential to grow the health insurance pool in positive ways, improving resilience and stability. This is, of course, provided that the more immediate threat of medical cost inflation can be addressed in a timely fashion.

Epidemiological Trends

Driven by environmental factors, economic transitions, demographic change, and medical developments, the incidence of health risks is constantly changing. More recently, global climate change impacts have also become increasingly visible, along with their impact on health risks. Monitoring and analysing these changes is important to understand and guide the development of the health system and health insurance in the medium term.

The trends in disease have been changing across Asia. Changes in the nature of health concerns have consequences for the overall cost of health care and the incidence of different services.

Contagious diseases have been reducing as vaccine efforts have continued to expand. Road accident mortality has also been improving. In the annex, Table 16 provides some statistics illustrating these impacts. **At the same time, many non-communicable diseases have been increasing.** These diseases can be more costly to treat including cancers, heart-related challenges, diabetes, etc. The incidence of obesity has been increasing, regardless of how it is measured, in all countries. Cholesterol levels, a key indicator of cardiovascular risk, have been increasing in many Asian countries. At the same time, data in the annex at Table 17 shows mortality rates have been kept broadly stable indicating that the treatments are playing their role in extending life.

More expensive treatments tend to be needed for these increasing disease incidence challenges. Although medical treatment costs vary by treatment and service provider in any jurisdiction, the same treatment also varies considerably across jurisdictions in absolute terms and

There are many sources for treatment cost benchmarks. One example is the Singapore Ministry of Health, which provides a public-oriented set of benchmarks to inform patients about decisions they may be facing regarding surgery and related anaesthesia and hospital costs.

relative to income levels. Table 11 illustrates this variation whilst showing how a shift in the disease incidence also leads to a change in the levels of costs incurred.

So, changes in trends, especially the shift to higher incidences of non-communicable disease, are a theme across many jurisdictions in Asia in addition to the pandemic experiences of recent years. The following table illustrate the fact that there is variation across the region but that, within each jurisdiction, the mix of costs and incidence is changing in ways that increase pressures.

Table 11: Comparative Treatment Costs illustrate variation across Asia

Jurisdiction	Cost of treatment: Total Knee Replacement		Cost of treatment: Living donor kidney transplant		Cost of treatment: Insulin for 1 year	
	$USD thousands	Percentage of GDP per capita	$USD thousands	Percentage of GDP per capita	$USD	Percentage of GDP per capita
Australia	$18 - $28	30%	$65	100%	$450	0.7%
Brunei						
Cambodia	$7 - $11	290%	$22	1,670%	$450	14.5%
China	$11 - $17	90%	$45	290%	$480	3.1%
Chinese Taipei	$12 - $18	30%	$35	80%	$550	1.3%
Hong Kong	$22 - $32	40%	$70	110%	$1,200	2.0%
India	$5.5 - $9	230%	$16.5	520%	$350	10.9%
Indonesia	$8 - $12.5	180%	$28	490%	$420	7.4%
Japan	$16 - $24	50%	$60	160%	$800	2.2%
Laos	$5.5 - $9.5	270%	$18	640%	$380	13.6%
Malaysia	$9 - $14	70%	$35	230%	$400	2.6%
Myanmar	$6.5 - $10.5	710%	$20	1,670%	$400	33.3%
Philippines	$8.5 - $13.5	220%	$30	610%	$600	12.2%
Singapore	$35 - $50	40%	$85	80%	$1,100	1.1%
South Korea	$14 - $22	50%	$55	140%	$650	1.7%
Sri Lanka	$5 - $8.5	150%	$18	410%	$320	7.3%
Thailand	$10 - $16	150%	$50	590%	$550	6.5%
Vietnam	$7 - $13	190%	$25	470%	$500	9.4%

Source: Hospital price lists based on private room top-tier services, medical tourism indexes, Health Action International, Insulin based on the retail cost of modern insulin pens (the global standard of care). GDP from IMF and World Bank.

Climate change also impacts health risks by changing the exposure to and incidence of health events. This can include increased exposure to extreme heat, worsening air pollution, and the health-related impact of climate-related natural disasters. Academic literature also identifies changes to the incidence of tropical diseases, and the impact of increased food insecurity on nutrition, with subsequent health impacts.

On one hand, these impacts may be longer-term, but many are currently more apparent. As a result, they have led to some product innovation in the shorter term and can be expected to do more. See the box for the SEWA case; noting that a similar product has subsequently been introduced in Hong Kong[12] and others are expected to follow. This innovation is a welcome development provided that regulatory and system settings are not constraining.

Perhaps one of the most discussed innovations is the heat stress parametric micro insurance developed and distributed through the SEWA (Self Employed Womens Association) in India.

The insurance pays out into digital accounts based on a trigger. When the temperature exceeds 40°C there is a payout of INR 400 ($US 4.80). Many women work in locations where temperatures exceeding 50°C are possible in the hottest months. Claimants are advised immediately by text message. Beneficiaries use funds to protect crops from spoilage, preserving income, or to supplement lost income, and avoid heat stress working conditions.

The premium is INR 250 ($3) annually which is partially subsidised.

Product delivery

Sustainability for health insurance can be addressed with the additional support of market innovation. This offers the opportunity to expand the market, reduce administrative and claims costs, and leverage better health and customer service outcomes. All of these goals would improve the financial performance and help offset some of the negative impacts of medical cost inflation. Limited scale economies and complexity of product administration especially for claims, create cost burdens that can be attacked and reduced to advantage.

Technological innovation has been increasing, especially since the pandemic period, when alternative delivery of services and digital channels became increasingly important. This digitisation push has extended to artificial intelligence applications that are being developed at a rapid pace.

[12] Refer WEF (2025b).

In many Asian markets, health insurance continues to be distributed either through traditional agent networks to individuals or through group schemes via employers and insurance brokers to their employees. Bancassurance and “direct to consumer” channels are increasingly relevant, and some countries are seeing partnerships with internet platforms and other innovations.

Innovations in delivery can extend beyond distribution. Customer service, including onboarding, underwriting, and claims handling, is increasingly looking to find efficiencies through the application of technology via digitisation initiatives and developing artificial intelligence applications.

Service delivery can extend beyond insurance administration. Looking for new service delivery options for customers, such as telemedicine, has also brought benefits. Enhancements to operational efficiency in healthcare and in the interface between healthcare providers and insurers will also reduce overall health costs and help offset medical cost inflation.

To that end, **insurers and healthcare providers need to innovate together** in terms of service delivery, operational efficiency, and patient engagement. This initiative needs to ensure that both parties find solutions that can leverage each other’s interests to find substantially re-engineered processes. If each group works in isolation, solutions will be limited to those that take the processes of the other partner as fixed – an unnecessary constraint.

Where there are substantial underserved groups, product and service delivery innovations may be needed. Two areas for attention could be to:

- consider a wider use of simplified products; and
- introduce compulsory coverage for temporary migrant workers,

both of which would potentially increase the pool of insured clients. At the same time, it is useful to consider the balance of cost with the provision of appropriate and relevant benefits to these particular client groups.

In some jurisdictions, “hospital cash” products have been introduced and may be worth expanding. Potentially, these products might provide additional services beyond the fixed hospital stay-related payouts to reflect customer needs, but at least they demonstrate the relevance of product innovation. There are other examples of insurers introducing a more “basic coverage” product to improve affordability for lower-income customer segments.

Insurance for temporary migrant workers is a feature in some markets either as a "recommended" or "encouraged" product or as a compulsory requirement. Compulsion can ensure increased coverage whilst advancing social goals[13]. Appropriate cover for migrants may extend beyond local health care provision, suggesting the opportunity for product and benefit innovation[14].

Aligning Stakeholder Incentives – providers and patients

Consumers and medical service providers are key to finding solutions to medical cost inflation challenges in the health system. Together, they can influence the use and potential overutilisation of health services through misaligned incentives. Without engaging in solutions to misaligned incentives, any other efforts are likely to be limited, if they are effective at all.

For consumers, where benefits are supplementary to the basic health system, it is practical to place caps on benefits. For example, a service may be available at a defined frequency (e.g. once per year) and subject to a maximum reimbursement amount. This may work well, for example, for services such as eye tests and reading glasses, or preventative dental hygienist services.

In other situations, consumers and doctors may both have an unsustainable incentive to increase service utilisation and claim costs. When benefits are linked to but extend basic coverages, such as those that relate to advancing the timing of services, such as "shorter waiting lists", access to a more expensive standard of room in a public hospital, to a more costly private hospital, or simply to reduce out-of-pocket costs that would otherwise be incurred, then the situation changes.

These incentives have to be carefully controlled if the health insurance system is to be sustainable. Cost-sharing mechanisms with clients, co-payments and deductibles are critical to avoid overutilisation[15]. However, these co-pays have to be carefully considered as they can adversely impact necessary medical access for low-income population groups.

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[13] The United Nation's Sustainable Development Goals include conditions and security for migrant workers as part of their targets.
[14] See the case studies for an explanation of recent changes in Brunei regarding migrant workers. Asia Insurance Review (November 2025) also reported on the implementation of such arrangements in Thailand. Also, our paper GAIP (2023), "*The Solutions Landscape*" includes an annex that examined different types of compulsory insurance across the region including that for foreign workers, illustrating the scope for broader compulsion.
[15] Numerous studies have found evidence that lower co-pays encourage over-utilisation.

Design of co-pay contributions can incentivise directed use of services and products, such as providing lower co-pays for generic equivalents to brand-name prescription drugs, telemedicine and other lower-cost but accessible services, or a network of preferred medical groups where negotiated fees and service standards are part of a partnership with insurers.

Changes in rules or preferences may well serve one group of providers and disadvantage others. For example, lower cost more accessible telemedicine may be useful for patients and reduce costs for some services but can disadvantage providers dependent on direct patient engagement undermining their viability if they do not respond.

In some Asian jurisdictions, cost sharing has been progressively reduced through competitive pressure on benefit design, reaching levels where incentives were clearly working against the sustainability of the system. **Governments have stepped in to oblige a minimum level of contribution** when the market was not able to deliver it without such intervention. In other cases, some constraints in regulation prevent such action and may need to be revisited, or at least carefully monitored.

Increasingly, positive incentives are also being incorporated in health provision and financing. Co-pays and deductibles may be a “stick”. The “carrots” being positive incentive structures, are emerging in product features that support preventative care, health maintenance, and healthy lifestyles.

Stakeholders have varying views on whether they are seeing lower claims as a result of these initiatives. In some cases, increased screening has led to some cases being identified that require treatment. Academic literature supports the cost savings from early intervention, although it notes that the extent of these savings varies depending on the condition. Some conditions have very high benefits from early intervention whereas others show less conclusive evidence. But for insurers, it can be difficult to discern the savings from an earlier intervention in their own claims and financial data.

Healthy lifestyle programs offer promise. There is academic evidence that these programs can reduce health care costs, particularly through reduced primary and specialist care visits. The programs also deliver benefits to employers through reduced absenteeism, improved employee retention, engagement and productivity. For insurers, the more regular engagement through health apps on mobile phones can build stronger brand loyalty and customer retention. These programs can improve diet, exercise and sleeping habits. They can also embed incentives that increase program engagement rates.

However, there is also a tendency for engagement to drop off over time creating questions of sustainability. For participants in programs for one or two years, the potential for longer-term health benefits can be more questionable. Not all insurers see the benefits of these programs clearly to assess against costs, and some benefits emerge for employer clients so are difficult to capture in management reporting. Some insurers have also varied the cost of incentives provided and seen negative feedback from users (potentially due to the lack of visibility of all benefits impacting decision making) – therefore, this product component needs careful management.

At the same time, many consumers may be cautious about healthy lifestyle programs. Careful implementation is needed to reduce or even avoid these risks. Concerns about data privacy may be important for some consumers. Insurer-led programs can also incentivise lower-risk healthy lives to participate and receive incentives, delivering a form of adverse selection. Where healthcare and health insurance systems are fragmented and create inequalities, adding a wellness program may exacerbate those challenges and bring negative reputational consequences. Cultural issues such as attitudes to mental health also need to be carefully considered.

Consumer awareness as a source of weak demand

For health insurance, as for other insurances, weak demand is attributable in part to a lack of consumer awareness. Recent research has highlighted that many Asian countries see health-related risks as important but less so than job security and employment. In emerging markets, 1/3rd of people indicate that they are not aware of insurance sufficiently to purchase it. Importantly, ¼ of respondents in advanced Asian economies also have this response[16]. Other barriers to purchase include perceptions that costs are too high, value is poor, or that government services are sufficient for their situation. Lack of product awareness is broadly independent of age. When health cover is provided through an employer of the government, consumers feel little incentive to purchase further health-related products on the individual market.

These concerns contribute to the fact that, for some jurisdictions, health insurance policies reach only a small proportion of the population – often 30% or less.

Public education is often advocated by the insurance sector, and it is clear that a positive role can be played. Governments benefit from a larger insurance pool and contribution to

[16] Source Swiss Re (2025).

overall health costs as it shifts some costs from national schemes and some services into private providers, helping overstretched public systems to focus on areas where their services are most critical. Many governments have opportunities to incorporate references to and education about private health insurance coverage in their public messaging on health and health financing more generally.

In addition, governments and insurers can leverage awareness of the public system. In some countries around the world, there has been a push for increased uptake and formalisation in the public system. This effort has, serendipitously, increased awareness of health issues, health risks, and the potential for and take-up of private insurance.

There is mixed experience of such parallel take-up in Asia. The correlation between awareness in public health schemes and the purchase of private health insurance is varied. Some countries have experienced negative “crowding out” effects. Others have seen a positive effect or a neutral outcome. For example, studies in China found that enrolment in some rural social health insurance schemes initially had a negative correlation with private health insurance enrolment, but that this changed to a positive correlation and became more complementary over time. In Thailand, the two elements are largely uncorrelated.

This experience suggests that seeking the opportunity of public education plans leveraging public scheme operations is worth considering but may be sensitive to implementation and local conditions.

Regulatory and Policy Environment

There are many ways that governments elaborate policies that impact the sustainability of health insurance. This section focuses on some key areas where opportunities exist to ensure positive outcomes.

Currently, with few exceptions, premiums, benefits, acceptance of risks, and renewals are not subject to political controls in Asia. There are some short-term pressures to limit rate increases in the face of political concerns about premium affordability. In particular, Bank Negara Malaysia has issued specific guidance on spreading premium increases in response to medical cost inflation over a three-year period, with specific premium increase freezes for older citizens and the opportunity for policyholders who lapsed recently in the face of premium increases to be reinstated without needing to be underwritten again (further elaborated in the next section).

Public debate can also include the challenge of providing ongoing coverage for "pre-existing conditions" or access to insurance for people of "high risk". Even when pre-existing conditions must be covered (as is the case under IRDA regulations in India), insurers may still impose a waiting period on claims related to those conditions that last several years.

Should obligations that expand access at the cost of private insurer flexibility become more widespread or permanent, additional steps will be required to support their ongoing viability. This likely will include a risk equalisation approach across insurers.

Although private health insurance benefit structures are often flexible in design, products that interact with the national base system will have features that necessarily follow the base system structure. This may constrain the opportunity for alternative products for underserved markets and, if so, should be reviewed.

As noted above, some governments have recently moved to introduce mandatory levels of co-pay[17]. In some cases, the co-pay is mandatory at a minimum level. In others, it is mandatory to offer a co-pay option partly because of other historic factors in the overall regulation of health insurance regarding benefit reductions. There will be competitive conditions where it is difficult for any one insurer to take a lead in such a direction, so government mandates may be the most effective way to achieve this outcome in a timely manner.

Finally, governments have a role to play in considering how taxes and charges encourage or discourage private health insurance provision. In many jurisdictions across Asia, premiums are deductible from personal income tax or are eligible for some relief, although this is not the case universally. In some jurisdictions, a premium-related duty applies to all insurances, including health insurance, increasing the cost of insurance. When low insurance penetration is a concern, especially for low-income groups, it may be worth considering how to provide an approach that does not discourage health insurance take-up by imposing charges. This is particularly relevant when it is considered that, if it is a barrier, the taxes may not be collected at all anyway given that there is no insurance written for that segment.

[17] These requirements have been mandated by government intervention in Indonesia, Malaysia, Singapore, and Thailand for example.

Case Studies

This section considers some illustrative cases in Asia. The cases are selected because they discuss current issues that are relevant to many jurisdictions. Of course, their application reflects the local conditions and circumstances but there are relevant illustrations of principles that may inspire other jurisdictions as they consider the most appropriate approaches to their own challenges.

The 2025 GAIP Insurance Global Innovation Competition Winners, Universitas Gadjah Mada of Indonesia, proposed an innovative solution using digital interface tools with clients, AI triage, networked connection to providers, and a "dynamic co-pay system" to align incentives whilst ensuring improved access to care.

The proposal puts decision making in the hands of the client whilst facilitating choice of co-pay that would support partnership between customers and insurers whilst also empowering the customer to make a provider choice.

Malaysia: Premium Regulation

Faced with increasing health insurance costs, public concern became a more pressing issue. This pressure was increasingly directed at government and the regulatory authority, Bank Negara Malaysia (BNM) given that they had regulatory responsibilities for both the stability and fair treatment of customers that included prior notification of premium adjustments with a power to intervene if it considers them to be unfair or unsound.

In response, BNM has introduced an "interim measure" that, importantly, responds to community concerns whilst also taking some initial steps that support efforts to constrain medical cost inflation. The interim measure has a defined and limited time frame.

Regarding premiums, the requirements introduced premium controls through to the end of 2026:

- **Annual 10% Cap**: Insurers must cap annual premium increases for medical insurance at 10%, and total cumulative premium increase by the end of 2026 must not exceed 30%.
- **Three-Year Staggering**: Any necessary repricing must be spread over a minimum of three years to minimize immediate financial impact on policyholders.
- **Senior Citizen Protections**: For policyholders aged 60 and above on plans offered by insurers with the minimum benefits (such as having the basic coverage options) and thus the lowest premium options for clients, premium adjustments due to medical claims inflation are paused for one year from their policy anniversary.

At the same time, measures to address medical inflation included a requirement for a mandatory co-pay option to be offered to clients. All new contracts have to have such a co-pay and existing products without a co-pay must be renewed by offering both the current benefits or a lower premium with a co-pay. The minimum co-pay is set at 5 percent of claims after a deductible of RM 500 per policy year although insurers may include higher requirements in policies if they wish.

These measures were moderated by some ongoing consumer protection measures that reflect the sensitivity of the intervention. The co-pay does not apply to emergency treatments, outpatient treatments for some critical illnesses (such as cancer or dialysis), and treatment at government healthcare facilities. Insurers can also have some discretion when dealing with customers in extreme financial hardship at the time of claim.

There was also a specific provision addressing fairness for customers who dropped their cover because of the recent premium increases before the changes were made. They can reinstate cover without any waiting period penalty or underwriting constraints.

A new standard basic product is also being developed that is intended to provide lower cost lower limit benefits as an option for those wishing to find a cheaper alternative to the current higher limit higher cost products and for those currently uninsured. This product is subject to discussion and consultation at the time of writing and is anticipated to be rolled out at the start of 2027.

Additional cost-based measures were also introduced including greater transparency provided by hospitals to clients regarding potential costs of procedures, and plans for a health service pricing system to standardise fees based on conditions. During the period, the parliament is also considering potential measures to further reform the system.

As a result, the BNM has **balanced public concern with market stability. They have addressed immediate consumer concerns. At the same time, they have developed a system that presents customers with options** for lower cost more basic benefit products providing flexibility and **increasing customer incentive alignment**. Administrative changes and co-pay changes also increase client incentives to align them reduce overutilisation of services. Although it remains to be seen how much these changes will take pressure off the high levels of inflation, they are sensible steps. The nature of an "interim solution" **recognises that the engagement between BNM, insurers, consumers and healthcare providers may become a collaborative effort** rather than a simple cost shifting effort.

Singapore: MediShield Life and Integrated Shield

The Singaporean national health insurance scheme, known as MediShield Life, is administered by the Central Provident Fund Board (CPF). It is mandatory for all citizens and permanent residents.

Mandatory monthly contributions[18] are made into Medisave accounts. Additional voluntary contributions can be made by individuals or employers[19]. There are also some programs where the government makes contributions for some eligible individuals. Medisave accounts are used to pay premiums for the MediShield Life program. Subject to caps, the Medisave accounts can be used to contribute to the uninsured costs of inpatient stays, day surgery, chronic diseases and to contribute to private health insurance premiums. Accounts can be used for the individual and for approved dependent family members.

MediShield Life focusses on providing coverage for treatment in public hospitals in defined "Class B2 and C" wards for defined procedures. As cover is provided for pre-existing conditions, the program forms the basis of the national universal health coverage

[18] In 2025, the mandatory rates were 8% for those aged 35 and below, 9% for those between 36 and 45, 10% for those between 46 and 50 and 10.5% for all over 50. These rates apply as part of the CPF contributions and are subject to a monthly ceiling salary of $8,000 (from January 2026). Self employed rates vary between 4% and 10.5% depending on both age and trade income.
[19] For example, for their self-employed contractors.

scheme. An annual deductible varies by class of hospital ward. There is also a co-payment that ranges between 3% and 10% of the balance of costs.

Integrated Shield plans can be purchased through an approved private insurer. These plans provide enhanced benefits including coverage for higher ward classes in public hospitals and stays in private hospitals, and higher claim limits. However, they can include some exclusions for pre-existing conditions. There is also a co-payment, typically, 10% of the balance.

To further enhance the benefits above, customers can purchase a "rider" that reduces out-of-pocket costs. Typically, although only more recently, the co-payments would be reduced to 5% and capped at around $3,000 per year[20]. Some riders were also covering deductibles, effectively reducing out-of-pocket costs further.

Premiums for Integrated Shield plans can also be paid for from the Medisave accounts although there is an annual limit that means that this only partly contributes to the costs.

Taken together, the deductibles and co-payments inherent in the basic system, which help to ensure alignment of incentives, are eroded significantly by the riders that insulate customers from their effect. This inconsistency is problematic.

Faced with a situation where many scheme participants had low deductibles and co-payments as a result of purchasing Integrated Shield plans and riders, the Ministry of Health announced some key reforms in November 2025 regarding riders. These reforms take effect on April 1, 2026 and include:

- New riders will be prohibited from covering the mandatory deductible;
- The annual cap on the policyholder's 5% co-payment is increased from $3000 to $6000; and
- As a reminder, the co-payment cap does not include the deductible.

For policies purchased between 27 November 2025 and 31 March 2026, the new structure is required by renewal on or after April 1, 2028.
However, the policy intention is not simply to restore incentives where they may have created incentives for overutilisation of services. Rider beneficiaries do have a tendency to use services and make claims compared to other insured beneficiaries. But, in addition, it

[20] Subject to some conditions on choice of doctor. Earlier, a zero co-pay was an option.

is expected that the reforms will lower the cost of rider premiums – potentially by around 30% - making coverage more affordable and reducing the numbers of people who downgrade cover each year for affordability reasons. To that end, the change will balance cost control with efforts to reduce a "downward spiral", and retain a balance of services between private and public hospitals, reducing potential pressure on the public system.

This illustrates how **a challenging situation may require a reset that can only be provided through mandated action**. No individual insurer would want to be first to reduce coverage so materially without expecting to see its portfolio reduced significantly, if not become unviable. But the Ministry of Health and the CPF have incentives that are also aligned to finding a solution[21].

Although this step is significant and may be monitored through implementation, it is clear that **finding common incentives for action offers the potential to change the way that both financing and incentives work in the system toward a better balance**.

This is not the only recent change made to the system in Singapore. There are a number of others that illustrate that there are many levers that policymakers are applying to target the stability of the system:

- Under the "Healthier SG initiative", if a person enrols with a dedicated general practitioner clinic then their Medisave account may become more available for treatments of certain drugs and the person receives subsidies for certain screening tests and vaccinations;
- The annual claim limit for MediShield Life was increased from $150,000 to $200,000 in response to more expensive therapies, effectively transferring some higher costs back from Integrated Shield plan cover to the basic system;
- Coverage for outpatient treatments was expanded under MediShield Life;
- A one-time Medisave bonus for seniors and increased subsidies would offset increased contribution costs of these changes for many Singaporeans;
- Hospital financing changes moving from payments by service to payments by resident in their area of service.
- MediShield Life premiums to increase in a phased manner from 2025 to 2028, by up to 35%. The potential for contributions to insurance costs from Medisave withdrawals also increase subject to the targeted initiatives of support above.

[21] The Ministry of Health led the implementation of these reforms.

This further illustrates **the importance of collaboration between insurance companies and ministries and other government authorities in both the health and finance sector policy making areas**.

Philippines: Microinsurance

Health insurance in the Philippines starts with the universal health care known as the "PhilHealth" system which is funded through premiums scaling to 5% of monthly salary[22] with some 100% subsidies from government for the poor, disabled, and senior citizens.

PhilHealth benefits provide payments that act as reductions to costs incurred and, in effect, means that the cost for inpatient services in public hospitals is intended to leave a zero balance. However, enhanced ward accommodation, or private hospital services, can be expected to leave a material remaining balance. Special benefit lists are provided for very significant catastrophic illnesses, maternity and newborn packages, and significant outpatient treatments such as dialysis, emergency care without admission, etc. They also provide a primary care system with outpatient clinics designated to act as a "family doctor" providing consultations, accredited and defined primary care, diagnostic tests, medicines, and screenings.

Given the potential for significant out of pocket costs, most middle-class Filipinos and foreign workers access additional insurance through HMOs that pay benefits on top of and after the benefits from PhilHealth, often provided through employer relationships. This provides, amongst other things,

- Greater access to clinics as the PhilHealth system is still being rolled out progressively;
- Coverage for more private wards in public hospitals
- Emergency room access in a private hospital without the need to pay a deposit
- Higher limits for coverage.

[22] For employees, they pay 2.5% and the employer pays 2.5% up to a cap of 100,000 pesos per month salary.

However, there has remained a concerning gap for low-income earners. The authorities have responded to provide subsidies to the PhilHealth scheme and insurers have responded to provide a targeted product to supplement lost income and support additional out-of-pocket costs. These products are built upon:

- “Hospital cash’ benefit models drawing on international experience.
- A critical distribution channel focussed on mass distribution to key customer groups; and
- Emphasis on low-cost affordability of products and services.

By law, “microinsurance” products in the Philippines can have a premium up to 7.5% of the daily minimum wage (currently around 50 pesos or USD 0.85). To provide products for such a small cost, insurers have adopted a “sachet” concept akin to buying laundry detergent in affordable sachets when the whole bottle is quite a large outlay. Some products, for example, have terms of 4 months instead of being annual to deliver this concept.

In line with the hospital cash model, products tend to provide reimbursement for nights as an inpatient in hospital but do not engage in paying hospitals directly. Products are provided with no medical underwriting but do tend to have a simple 15 to 30 day waiting period to avoid anti-selection risks. They provide a fixed figure benefit of “daily hospitalisation income” up to a maximum number per policy period, capping benefits to further reduce risk of abuse.

Interestingly, an “out of hospital” benefit is also common and a welcome example for other jurisdictions to consider. In the Philippines case, the product often provides a cash assistance benefit on diagnosis with Dengue Fever without requiring hospitalisation, responding to local concerns.

Distribution innovates through models as variable as mobile phones, pawnshops, community organisations, and mutual benefit associations. This contrasts to an agent dominated more conventional insurance distribution system. It is estimated that these products have reached more than 56 million Filipinos, or about 50% of the total population – one of the highest microinsurance penetration rates in the world.

The case illustrates how a product that finds a useful purpose, supplementing health financing gaps with meaningful benefits at affordable prices, and distributed to connect to customers, can be very effective as part of the overall health insurance landscape in a country.

Indonesia: Finding political balance for reforms was needed in the face of a focus on zero co-pay based unsustainable products

Faced with concerns about high medical inflation trends at 2 to 3 times price inflation, claims ratios that were unsustainable consistently exceeding 90 percent, and concerns about the moral hazard impacts and overutilisation, the authorities in Indonesia (the OJK in particular) proposed a mandatory 10 percent co-payment rule in early 2025. Customer co-pays were also proposed to be subject to maximum nominal amounts to protect against catastrophic cost events in terms or both outpatient and inpatient claims.

Public pushback, largely from consumer organisations, raised concerns about the financial burden on vulnerable groups, a "breach" in the expected contract of existing clients with "full coverage", and some concerns that this would not advance improvement in the relatively low penetration rate for insurance in Indonesia. Legislators also became engaged through a commission of the House of Representatives with concerns including the potential for the need to balance consumer and industry interests.

The OJK engaged with the legislators, leading to a revised approach[23] that included several new elements:

1. The 10% mandatory risk sharing model was replaced with a 5% optional model.
    a. This meant that insurers had to offer one product without risk sharing to address concerns about benefit reduction. These products are not "price controlled" but cannot have "arbitrary price increases" under the regulation and can only be priced once a year.
    b. The authorities also would provide a product with a 5% co-payment. If a company wishes (and it is expected that most would do so) they can offer a co-pay product at the 5% level. The fixed maximum nominal amounts were retained.
2. A medical advisory board was established that would oversee service quality and address concerns that efforts to reduce overtreatment did not lead to "under-treatment".

Existing insurers have a transition period through to December 2026 to align products to the new requirements.

[23] Known as Regulation No 36 of 2025.

Although the results of this reform remain to be realised, the lessons from it are emerging. Firstly, processes in policymaking will need to bring stakeholders including legislators into the effort. Second, refinements to an opening position may leave us with useful advances. Thirdly, giving options may still allow us to guide many customers to the one that leads to avoiding a zero co-pay option due to cost. Fourthly, the insurance distribution and renewal process may well deliver significant steps in reform – highlighting that insurance processes can be leveraged for benefit[24].

In line with our concluding principles below, incentives are key and co-pays are part of that environment. With a zero co-pay environment, high medical inflation is inevitable as is unsustainable health insurance. In the Indonesian case, it is now up to insurers to price the zero co-pay product above the 5% co-pay product so as to provide sufficient incentive for clients to opt for the co-pay product and to manage that process effectively through ongoing rounds of renewal. If they can do this, the framework will generate benefits toward sustainability. If insurers focus on providing zero co-pay products, for example to higher income earners as a target market, then they will likely continue to see problematic results in terms of the sustainability of their portfolio

Brunei: Improved health financing by expanding health insurance's role

Health services have largely been provided by the government through well respected service delivery channels at little or no cost. In response to rising budget costs, as of July 2025, foreign nationals who held certain foreign workers and permanent residents were required to have a minimum private health insurance coverage. In 2026, this was further extended to all private sector employment pass holders and their dependents and also to foreign students. If they are not insured, they must meet their own costs directly.

For the most part, insurance is provided through employers making group arrangements with insurers. In many cases, employers already had some form of insurance but these reforms have standardised the practice.

Although the number of impacted patients is not large, it is material for a small country as Brunei has a population of just 470,000. Around 25% of the population are not citizens.

[24] This leverage and integration of insurance incentives have been a common theme across our papers aimed at reducing protection gaps. Silo approaches that do not consider both insurance and non-insurance solutions as interrelated tend to be sub-optimal.

This is an example of efforts to use the private insurance mechanism to expand the financing base for the health delivery system. It has a clear impact to reduce the pressure on financing and health service delivery.

Although many countries in the region have some form of mandatory insurance for temporary migrants, the system can be less comprehensive in application or enforcement and may require coordination between ministries of labour, immigration, health, and the financial sector providers.

Toward a Set of Principles for Sustainable Health Insurance

Through the development of this paper, discussions with stakeholders and other experts, along with quantitative and qualitative reviews can be distilled into the following set of high-level principles that have relevance across Asia and beyond.

Principle 1: Private sector insurance is an important contributor to health financing and the financing pool should be expanded to support sustainability. Efforts that reduce this source of health financing should be avoided.

Faced with challenges to provide adequate financing, it is important that opportunities are taken to expand the pool of resources available. All parts of the system are exposed to the challenges of medical cost inflation. As a result, all parts of the system must work together to advance solutions.

Negative spirals need to be averted. Where there is a risk that private insurance will decline and see a material withdrawal of participants, this is a negative outcome to be avoided[25].

Instead, **the goal is to grow the financing pool** rather than reduce it. Options may include:

- Specifically reviewing the incentives for private health insurance purchase, including targeted customer research of those who do or do not make such a purchase;
- Examining opportunities for public education programs about the way that private and public health financing integrates to serve citizens;
- Considering ways to increase the pool through ensuring that group insurance schemes can be offered by employers for their employees without regulatory impediments, increasing the potential risk pool, especially of healthier risks.
- Considering a wider use of simplified products;
- Introducing compulsory coverage for temporary migrant workers; and
- Ensuring taxation systems do not disincentivise younger, healthier lives from taking out private insurance.

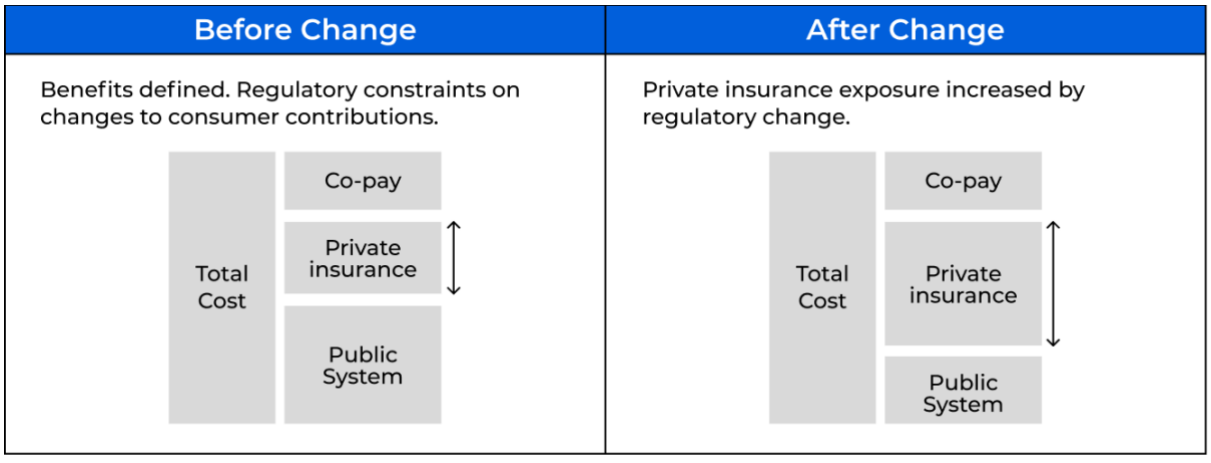
[25] On occasion, market withdrawal of an insurer can take place for a range of reasons that are not related to market conditions. For example, insurers that are part of a larger international group may be acquired and subject to strategic review.

Cost shifting needs to be avoided.

When private insurance offers additional benefits over and above the public system, savings measures in the public system may inadvertently shift these costs to the private insurers. This takes insurer exposure to medical cost inflation to another level, as insurers also have to then absorb the regulatory shift. Figure 7 illustrates the way that this adverse effect can result as the total cost and the co-pay may not change, leaving the withdrawal of public system contribution (the saving) simply being passed to the private sector. In such a scenario, insurers have no choice but to pass this impact to customers, but only after a delay. In competitive markets, some market withdrawal and reduced financing will be inevitable.

> *"**L'art de gouverner consiste à prendre le plus d'argent possible à une catégorie de citoyens afin de le donner à une autre**." – The art of governing consists of taking as much money as possible from one category of citizens in order to give it to another - attributed to Voltaire and his cynical commentary on taxation.*
>
> *Often transposed into English as "**The only fair tax is a tax on the other guy**", this approach to medical cost inflation would mean finding a stakeholder group that can be charged and who cannot object as strongly so as to cross subsidise others who have more political voice or power. **This approach does not address the root cause of the problem.***

Figure 7: Illustration of Cost Shifting Challenges



Faced with pressures in the system, solutions that involve cost shifting are counterproductive. **Governments have a critical role ensuring that reforms to the basic system make real change rather than cost shift to private insurers** and create challenges in sustainable insurance.

Principle 2: Affordable health services is a unifying and critical imperative for all stakeholders. Medical cost inflation is the most important current driver of affordability challenges for consumers, fiscal challenges for governments, continuity for health delivery stakeholders, and financial sustainability for insurers. Partnerships are key to finding and operationalising solutions.

Stakeholders have different goals, but affordability in the face of medical cost inflation is not just a common challenge, it is a unifying challenge. Whether it be fiscal stability, health service delivery, financially sustainable voluntary health insurance businesses, or affordability for employers sponsoring group schemes or individuals and households,

Effective solutions lie in ensuring that all partners are engaged together to address solutions that are consistent with social contracts, aligned incentives, mutual benefits, and effective partnerships. Governments should ensure that insurance, finance, social protection and health policymakers are engaged together. Health insurance providers, health service providers and consumers also need to be part of the solution. In particular:

- **The relationship between health ministries and financial sector regulators needs to be an operationally proactive partnership**. It needs to go beyond information exchange and transform into a forum for joint engagement in understanding challenges and developing solutions.
- **From this base of a unified government commitment, engagement with health insurers is important.** This engagement can bring forward opportunities where the government can lead in areas where the insurance sector itself or no individual insurer, has sufficient incentive to take action on their own. This includes collection of data (see below) and the imposition of minimum obligations on consumers.
- Health regulators have control, explicitly or through their leadership, regarding developing appropriate standards for health service delivery. They can provide guidance for practitioners. They can develop good practices or regulations on transparency of fees and charges provided to consumers (preferably in advance). They can engage in pricing and sourcing of pharmaceuticals. These are just a few examples where **interventions on services and service delivery are relevant for all stakeholders and, therefore, active engagement forums have to be energised to secure the best results.**

Principle 3: To build a sustainable health financing system, incentives need to be aligned across all stakeholders.

While financing volume and affordability are critical, long-term sustainability ultimately depends on whether incentives across consumers, providers, insurers and governments are aligned. For the overall system to be sustainable, especially in the face of the challenges from changing risks and costs, it is critical that no stakeholders have a material potential to exacerbate rather than support managing common issues. To that end, it is fundamental that policy settings and structures:

- Ensure incentives for all parties are aligned, including policyholders and service providers. This can be supported through:
    - Coinsurance and deductibles for clients
    - Transparency of costs that customers may incur as much as possible in advance, with options and choices. Incentives may include alternative co-pay outcomes when choosing between network providers and those "out of network" or advice on real-time options for services that may be more supplemental to core care goals. (see below on advance cost estimates for example).
    - Medical providers also have a role to play and can be supported by the development of schedules, cost-agreed services, treatment protocols, and pharmaceutical guidelines that balance cost whilst still providing sufficient flexibility to accommodate professional expertise in customer care.
    - Insurers should avoid generous benefits that encourage over-utilisation of services, especially those that create incentives for clients to engage with providers to seek or accept the need for additional services. This is especially relevant when incentives are reduced to the extent that customers move from any degree of caution balanced by potential out-of-pocket costs to a scenario where maximising services is the only motivation. Importantly, when market competition is significant and individual company leadership is problematic, it may require government-imposed constraints on product generosity despite the generally accepted need for change. To that end, Governments may need to step in to facilitate change when private market competitive settings prevent sensible and generally accepted change.

- Insurers can also emphasise benefits that provide incentives for customers to adopt preventive and other healthier options whilst still playing the role of providing meaningful cover. Wellness programs have a role both in this respect and by enhancing the customer relationship value, so they can reduce costs through both customer engagement benefits and claim incidence[26].

- **Governments have a critical role to play, including defining acceptable levels of service and treatment.** Health ministries, in particular, can work with insurers, medical experts, and insurance regulators[27]. Guidance can be useful for all of these stakeholders for a number of reasons, including the impact that they would have on optimising health service usage whilst controlling the risk of overutilisation.

Principle 4: Premium, renewal and other social constraints have to be very carefully managed.

Premium controls, especially when constraining increases, must be very carefully managed as they can undermine the stability of the insurance sector. Consultation, collaboration and the ultimate need for partnership are critical to both the health and insurance financial stability regulatory agencies. The same applies to product design constraints.

There is a real danger that private health insurance will not be functional with such constraints. To avoid these risks, governments need to:

- Ensure that they are not only considering their own financing challenges but also the financial sustainability of the insurance providers at the same time;
- Provide flexibility in pricing that reflects actuarial balance, and understanding the impact of constraints on this pricing;
- Manage collaboratively any short-term variation from actuarially balanced pricing;

[26] As is noted regarding healthy lifestyle approaches (refer page 34), these programs do enhance customer engagement so can reduce costs through customer retention and brand loyalty. Some stakeholders advised that claim impacts are more difficult to identify as the benefits may be longer term or the customer target group may be already healthier, whereas other stakeholders did report that benefits were discernable in terms of the client risk profiles.
[27] Sponsoring debate on the balance between costs and benefits including those provided by health insurance may be informative. Interventions to constrain premiums should also consider not only the costs of health services but the appropriate use of them. The Malaysian “basic product” proposal is an example of how governments have opened discussion on what might be a suitable benefit package to make available in the market.

- Provide risk balancing mechanisms when pricing adjustments are required for reasons based on social contracts or policies and there is a material risk that one or other insurer may have a greater and unavoidable exposure to an excessive concentration of higher risk claims. Where high risks have to be accepted by a market, and there is a range of players, a risk equalisation scheme is important for financial stability. Relying on consistent levels of social engagement and solidarity may be problematic.

The provision of catastrophic health care cost coverage should not be lost as a core goal when considering the social consideration of more frequent and ancillary benefits as part of public policy development.

Principle 5: Initiatives to reduce costs and improve service delivery can be advanced by facilitating digitisation and other technologies, including AI applications. Unnecessary constraints on any participants in the health delivery and financing system that prevent them from adopting useful or necessary innovations should be avoided.

The potential for change in service delivery has always seemed to be present, but is more evident now, especially as digitisation trends and Artificial Intelligence applications are mainstreamed at exponentially increasing rates. Reforms in service delivery, such as hospitals and clinics, can change both the administrative cost burden and the efficiency and cost of services – directly impacting claims costs to insurers. Reforms at insurers can deliver more efficient back-office processes, linkages to make administration more effective, reducing costs, as well as reducing fraud and improving customer service interactions.

Reducing costs and improving service delivery at both insurers and health service providers will support efforts to partially offset pressures to pass medical cost inflation on to customers. However, governments will have to ensure that they do not have unnecessary or unintended regulatory barriers to the adoption of sensible change and may need to proactively encourage or facilitate some efforts.

To that end, **insurers and healthcare providers need to innovate together** in terms of service delivery, operational efficiency, and patient engagement. This initiative needs to ensure that both parties find solutions that can leverage each other's interests to find substantially re-engineered processes. If each group works in isolation, solutions will be limited to those that take the processes of the other partner as fixed – an unnecessary

constraint. Improvements made for one stakeholder may not always achieve an overall benefit if they impact costs and utilisation rates in another part of the value chain for another stakeholder.

Cost management can also be supported by **introducing systems that improve the transparency of information to customers through advance advice** of total expected costs for services.

Governments may consider, from time to time, sponsoring an explicit study of incentives and motivations of all sector participants and of consumers in different segments to inform ongoing policy considerations.

Principle 6: Data is critical to policy development and also to sustainable and innovative insurance sector solutions.

Governments have a critical role to play to ensure that both public sector health data and private insurance data are collected, collated, and made available in a form that is helpful to innovation and development of all financing solutions, including insurance. Often, without government engagement, data sharing runs into roadblocks.

Data includes that needed for policy development, sustainable and innovative insurance sector solutions, effective operation of larger medical service delivery agencies, and transparency to clients. This includes, for example, data on medical treatment numbers and costs, insurance premiums and claims, out of pocket costs paid by patients, costs to government for state provided services, uninsured customer utilisation. Studies can also be sponsored to identify variation in costs to identify more efficient and effective delivery options.

Governments likely are the only actors who can ensure both public sector health data, private insurance data, and uninsured customer utilisation data is collected, collated and made available in a form that is helpful to foster innovation and develop financing solutions including insurance.

Customer transparency on potential service costs also greatly assists initiatives where this can be provided in a timely and sensitive manner to customers facing choices.

From Principles to Action – in the interim

The analysis above suggests that not all actions are equally urgent or substitutable. In the near term, failure to address utilisation incentives, pool size, and pricing flexibility will materially increase the risk of market withdrawal or implicit rationing, regardless of progress in other areas. The actions below should therefore be read not as an exhaustive list, but as a set of priority pathways for stabilising health insurance systems in the face of accelerating medical cost inflation.

The principles outlined above identify areas that warrant particular attention. They reflect themes that emerged consistently across jurisdictions: the immediacy of medical cost inflation, the need to strengthen financing arrangements, the importance of aligned incentives, and the critical role of partnership between health ministries, insurance regulators, service providers, insurers, employers and households.

Many stakeholders across Asia have already begun to address these issues. In several jurisdictions, insurers are reviewing benefit structures, brokers are working with employers to manage contribution increases, regulators are revisiting premium frameworks, and policymakers are assessing the role of private health insurance in the broader financing mix. Yet, the level of medical inflation means the collective impact of these efforts remains insufficient. The challenge is not a lack of activity but the need to deepen, coordinate and accelerate actions so that they are commensurate with the risks discussed in this paper, and to avoid adverse results of uncoordinated and counterproductive actions.

Given the magnitude and critical nature of health protection gaps across Asia, we need all parts of the system to work together effectively. Our forthcoming second paper with a health focus will extend the discussion to a broader examination of the ecosystem in which health insurance is a key component. Ultimately, the well-being and health outcomes sought can only be achieved through effective partnerships between all players.

That said, while we develop this second paper, which will bring with it further recommendations, including for the health insurance sector, this section sets out the next steps for some key stakeholders. These steps are not intended to be prescriptive. Rather, they reflect the practical implications of the analysis and principles in this paper.

Health Insurers

Private health insurers face immediate operational and strategic pressures arising from medical cost inflation, claims experience and regulatory constraints. In the near term, insurers can strengthen their resilience by developing a more detailed understanding of the drivers of claims cost increases, distinguishing between price effects, utilisation trends and mix changes. This diagnostic capability forms the basis for informed decisions on benefit design, pricing adjustments, medical management and engagement with regulators.

Where benefits and incentives have become misaligned, gradual adjustment is needed. Competitive conditions and regulatory constraints often limit the ability of any one insurer to lead change unilaterally. As a result, insurers may need to introduce benefit modifications progressively, protect low-income and vulnerable groups, and improve communication with policyholders to explain the rationale for change. The experience of many markets demonstrates that sudden shifts in benefits or contributions can undermine trust and reduce participation, ultimately weakening the pool.

Strengthening relationships with healthcare providers is also essential. Insurers have opportunities to work with hospitals and clinics, either directly or via third-party administrators, to develop agreed fee structures, treatment pathways and referral arrangements for high-cost, high-variability procedures. Improvements in medical management, including the use of telemedicine, digital tools and enhanced pre-authorisation protocols, can help offset the effects of medical cost inflation. Insurers can also continue investing in operational efficiency, claims automation and fraud detection to reduce administrative burdens.

Additionally, through engagement with both insurance regulators and health ministries, insurers should clarify their role within the national health financing system—whether primarily supplementary, providing enhanced access, or supporting catastrophic protection—and align product development, capital allocation and policy engagement accordingly. Opportunities exist to expand insurance coverage through simplified products, basic coverage options and group schemes, including for temporary migrant workers where permitted. Such expansion has the potential to increase the pool and reduce exposure to adverse selection, consistent with Principle 1.

Reinsurers

Reinsurers have a unique vantage point, observing claims experience and medical cost inflation trends across multiple markets. As illustrated earlier, sustained inflation shortens the time available to adjust portfolios significantly. Reinsurers can work with insurers to incorporate these scenarios into stress tests, portfolio analyses and public discussions on sustainability.

In addition, reinsurers can provide technical guidance on pricing assumptions, benefit structures and cost-sharing arrangements that have demonstrated resilience in other jurisdictions. They can also support knowledge transfer by sharing international experience on medical management, digital innovation, provider contracting and product reform.

Over time, reinsurers may work with insurers and regulators to explore more sophisticated risk-sharing mechanisms that help stabilise coverage in markets facing structural pressures. Reinsurers can also contribute to regional benchmarks on medical inflation and claims trends, supporting policymakers and supervisors as they assess system-wide resilience.

Brokers and Intermediaries

Brokers and other intermediaries play a central role in employer-sponsored schemes, which remain an important distribution channel across Asia. As medical cost inflation pressures emerge more visibly in group renewals, brokers can help employers understand multi-year cost trajectories beyond annual premium movements. This could include interpreting claims experience, illustrating the relationship between utilisation patterns and contributions, and evaluating the long-term effects of changes in cost-sharing, networks or benefit structures.

Brokers are also well placed to support communication with employees, helping to explain why benefit adjustments are necessary and how they support sustainability. As benefit structures evolve, brokers can support employers in adopting networked provider arrangements, wellness programs, or digital health services where appropriate.

In several markets, intermediaries can facilitate the extension of coverage to SMEs, informal sector groups or other collectives, thereby increasing participation and reducing adverse selection.

Regulators and Supervisory Agencies

Regulators already face the dual responsibility of protecting consumers and ensuring financial stability. The challenges highlighted in this paper suggest that, in the face of rising medical cost inflation, insurance supervisors, health ministries, and potentially social protection agencies will require even closer coordination.

Where premium controls or approval processes apply, regulators may need to ensure that these arrangements allow for timely and evidence-based adjustments that reflect genuine cost pressures. Without such flexibility, insurers may be unable to maintain actuarial balance, increasing the risk of market withdrawal or erosion of coverage. Similarly, product design constraints that limit the use of cost-sharing or network arrangements may warrant review where they inadvertently reduce the system's ability to respond to inflationary pressures. Where competition impedes sensible adjustments, regulatory leadership may also be needed to coordinate market-wide adjustments that individual insurers cannot implement unilaterally.

Regulators can also encourage collaboration between insurers and health service providers, particularly in the development of treatment protocols, transparency requirements and agreed fee arrangements. Over time, regulators may consider embedding medical cost inflation stress tests into prudential frameworks to better anticipate emerging risks.

Finally, regulators have a role in facilitating the responsible use of technology and data, ensuring that regulatory settings do not inadvertently prevent insurers or providers from adopting innovations that could improve efficiency, reduce fraud or enhance customer service, consistent with Principle 5.

Policymakers in Health, Finance and Social Protection

Policymakers face a complex set of objectives: ensuring access to essential services, maintaining fiscal sustainability, supporting economic resilience and enabling private sector participation where appropriate. The health protection gap estimates presented earlier underscore the importance of a diversified financing mix, with private health insurance playing a role alongside government spending and out-of-pocket contributions.

A critical next step is for policymakers to articulate clearly the intended role of private health insurance in the national health financing architecture. Whether its role is

primarily supplementary, complementary or integrated into broader cost-sharing arrangements, clarity will support coherent policy, regulatory and operational decisions across ministries and agencies.

Policymakers may also wish to review tax settings, premium-related duties or contribution incentives that influence participation, especially among younger and healthier populations. Addressing barriers to coverage for underserved groups—including low-income households and migrant workers—can reduce protection gaps and strengthen system-wide resilience.

Investments in data infrastructure are increasingly essential. Effective policy development requires access to consistent information on public utilisation, private claims and unmet health needs. Policymakers, working with regulators and insurers, can help develop frameworks for secure, privacy-appropriate data sharing that support innovation and improved service delivery, reflecting Principle 6.

Across all stakeholder groups, the message is consistent: stabilising health insurance systems in the face of medical cost inflation requires early, coordinated action on utilisation incentives, financing pool depth, and pricing flexibility, before more disruptive adjustments become unavoidable.

Conclusion, for now

The sustainability of health systems, delivery and financing, is under pressure. The most prescient reason is medical cost inflation impacting affordability for all participants. There are other concerns, but the levels of medical cost inflation currently seen have pushed it to the top of the list of concerns.

Sustainability of financing is a unifying goal for all stakeholders – governments, private sector providers, insurers, and consumers. This paper has spoken to this concern largely from the perspective of sustainable private health insurance. It has called for action in partnership between insurers and governments to ensure that the contribution of private insurance is supported and developed, not least to ensure that the health financing goals do not lose the contribution.

Diversity of systems and approaches across jurisdictions is clear. As a result, solutions have to be specific to those systems and approaches. However, some common themes have emerged in this paper that can provide some direction for action across the region as policymakers reflect on their own specificities.

This paper focused on the need for a sustainable pathway for private health insurance, a critical part of reducing the health protection gap in Asia. Financing of health is greatly advanced by sourcing all resources, including a viable and growing health insurance sector. As we researched the paper, it became clear that it is critical that governments and insurers work together with healthcare providers and consumers to find a balance that ensures health insurance remains sustainable.

Our forthcoming second paper with a health focus will extend the discussion. Health insurance is a component that must operate within the broader system. Just as we have advocated for a reinvigorated role for health insurers to expand financing support and health outcomes, it is important to ensure that all parts of the system work together effectively. Ultimately, the well-being and health outcomes sought can only be achieved through effective partnerships between all players.

Whilst working on the second paper, we encourage all stakeholders to share their feedback with us. Additionally, Governments can partner with insurers to take steps to turn these principles into actionable efforts.

Annex: Health Related SDG Indicators

Indicator 3.8.1. Universal Access to Health Services

This indicator is a measure developed from a range of sub-indicators and ranges between 0 (in theory) and 100 (for perfect access). For countries where the overall indicator is above 80, then the WHO report the figure as “80 or above”. There are four subsidiary indicators also reported covering (i) infectious diseases; (ii) non communicable disease; (iii) Reproductive, Maternal, Newborn and Child Health; and (iv) Capacity and access.

The following trends for each reported jurisdiction are available:

Figure 8

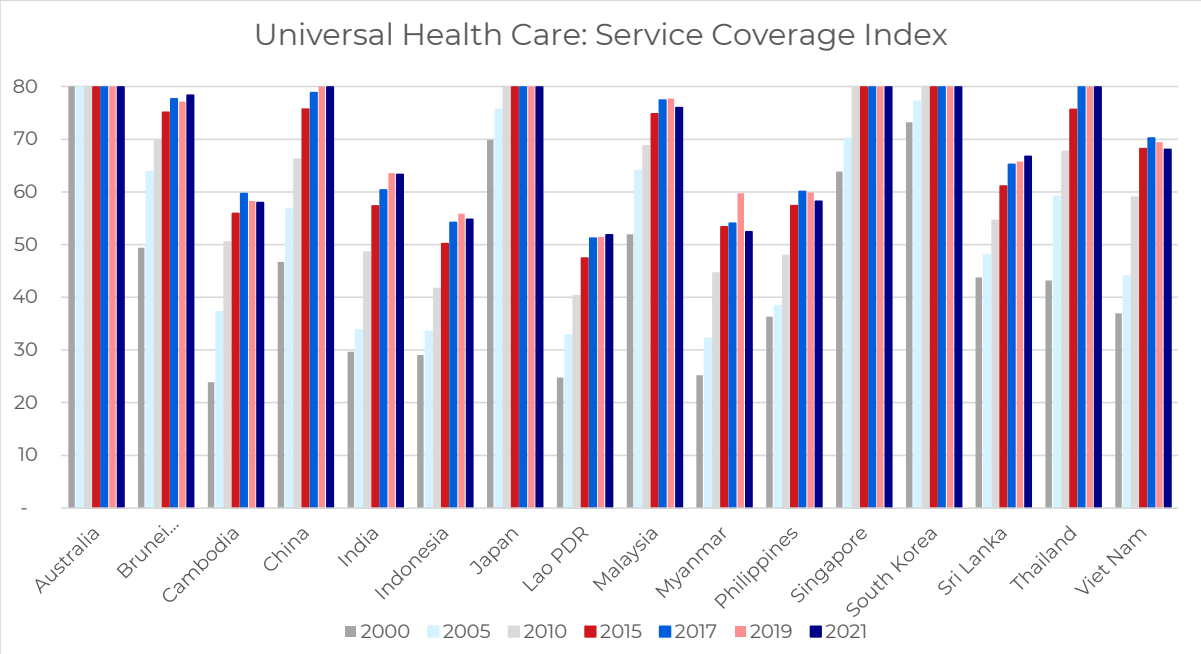
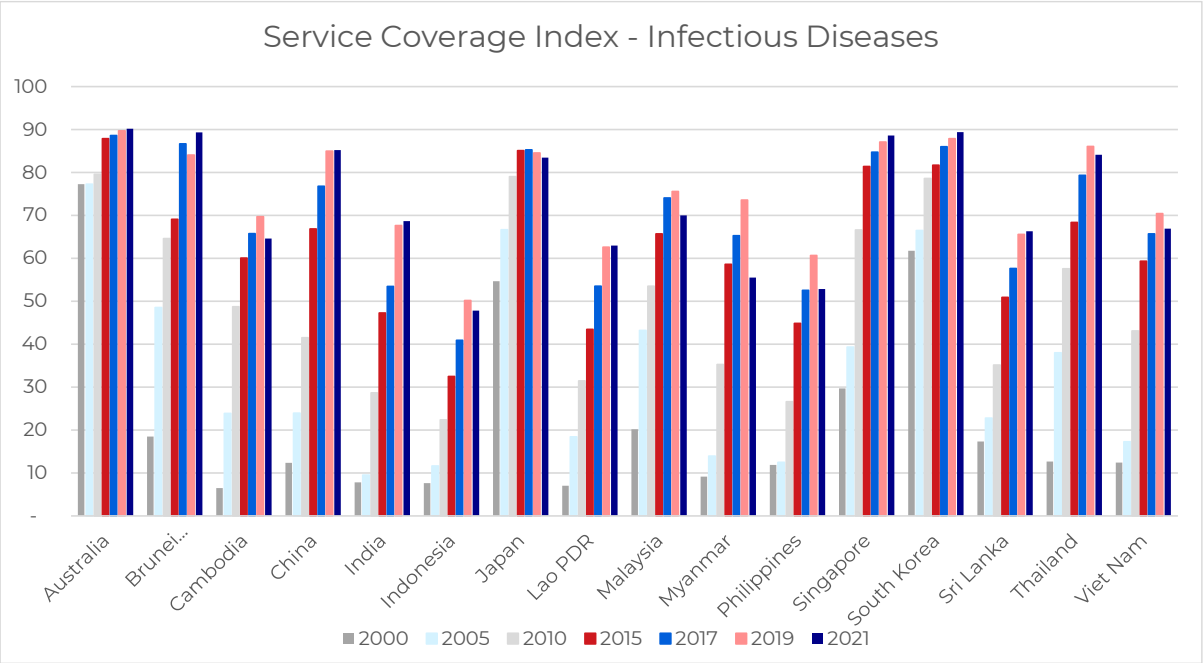
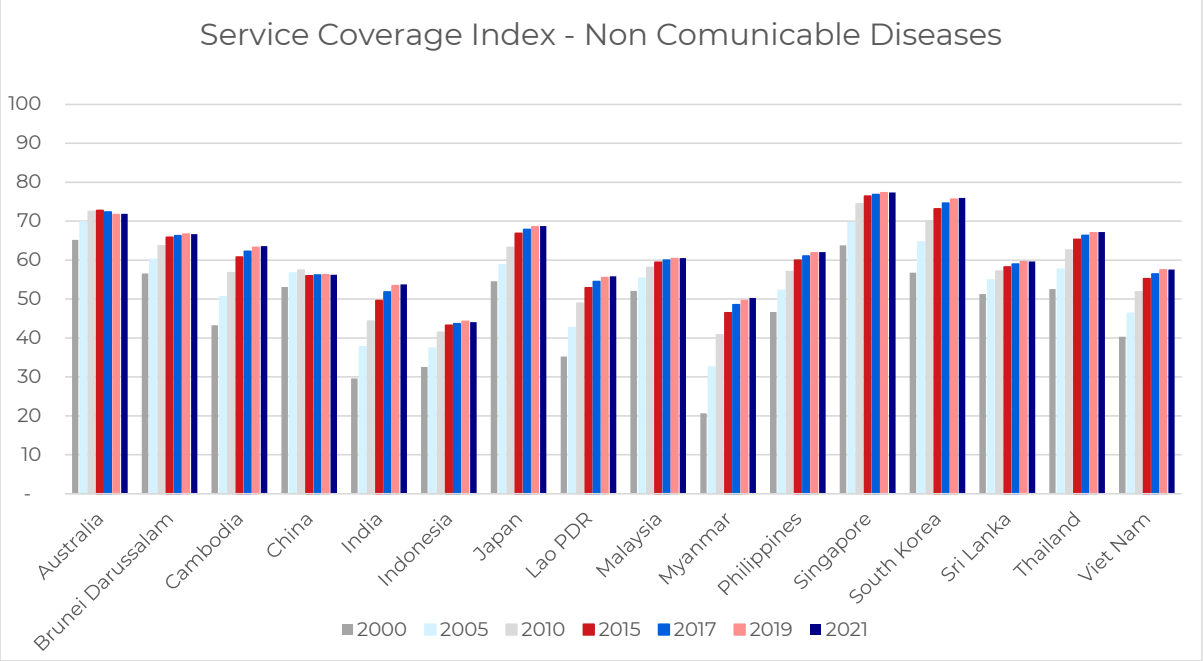


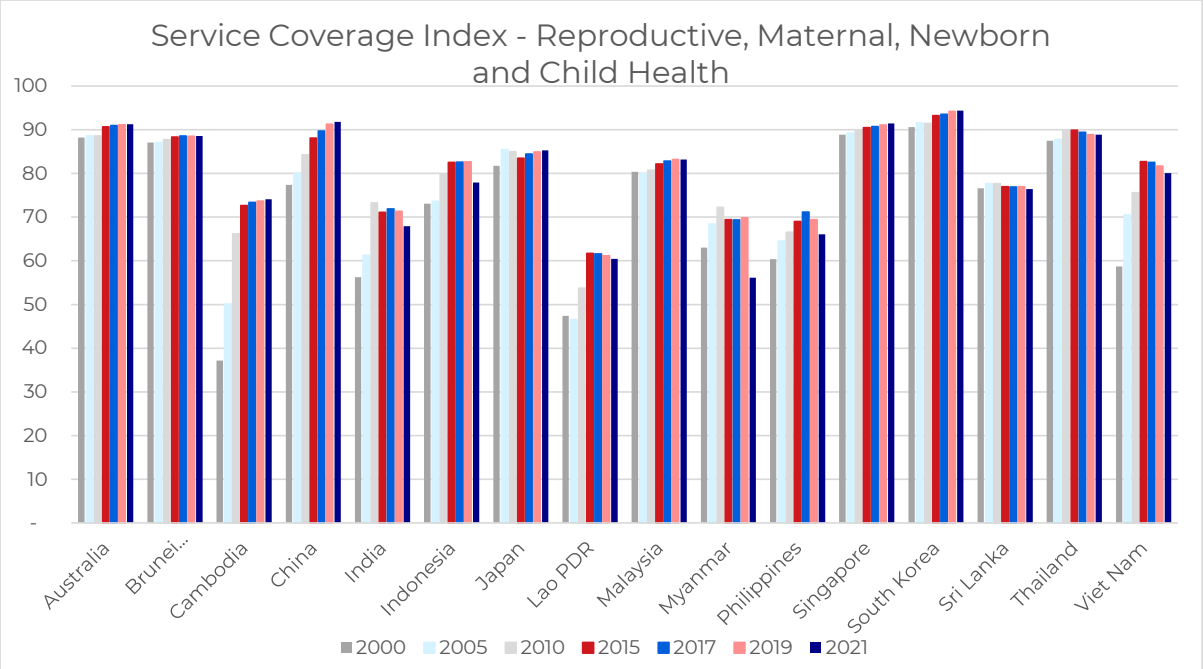
Figure 8 shows the improving trend for countries across Asia. Several countries are persistently in the “80 and above” range now whilst others tend to be progressing in the right direction.

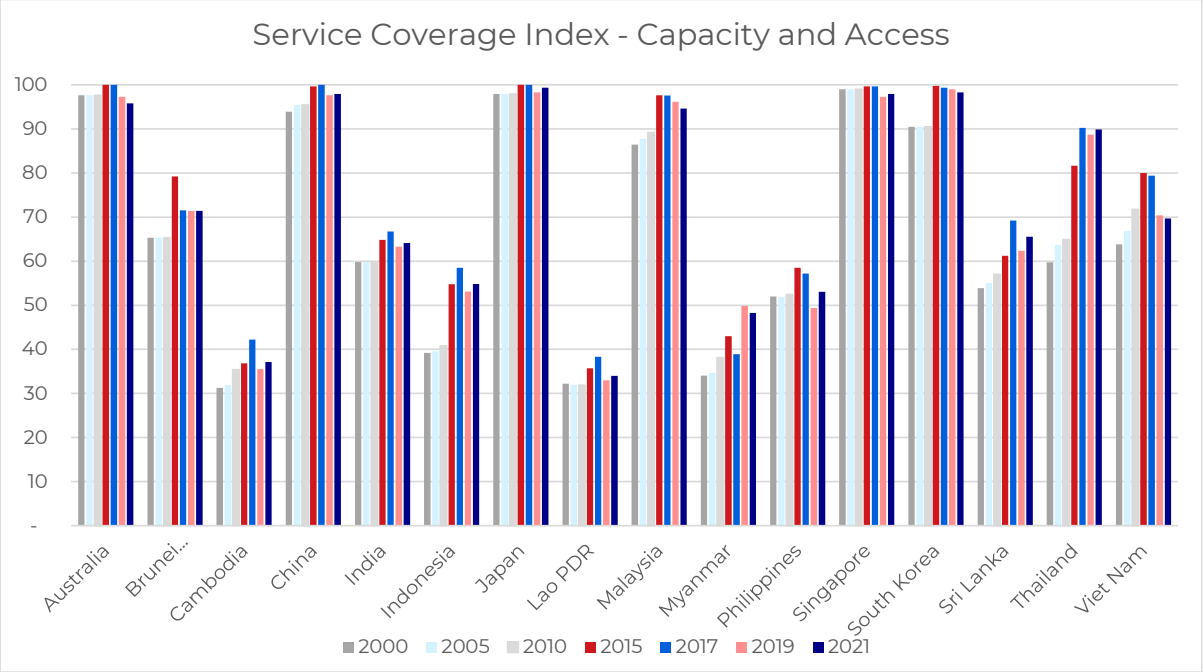
The equivalent charts for the four subindices are shown in Figure 9.

Figure 9



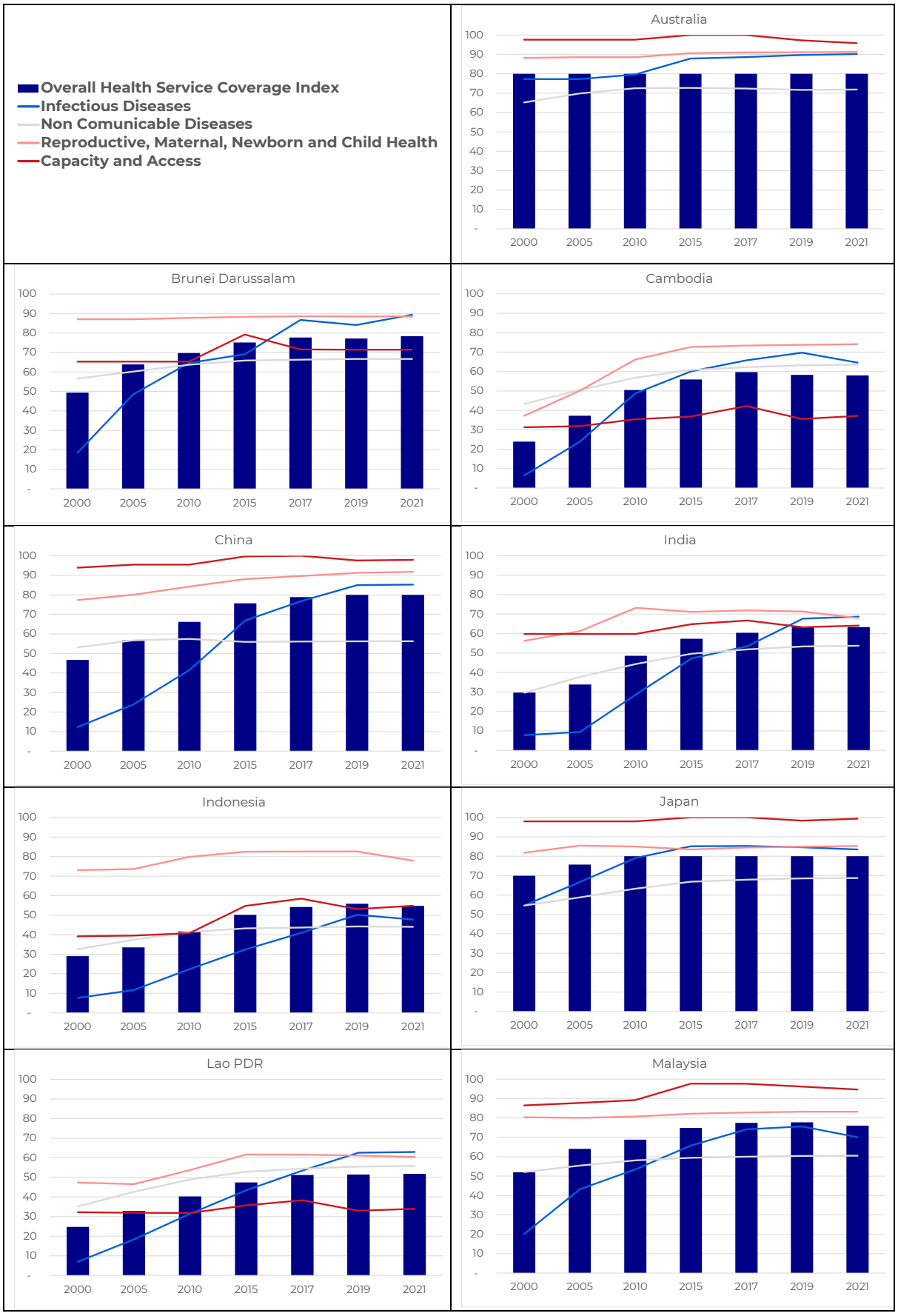


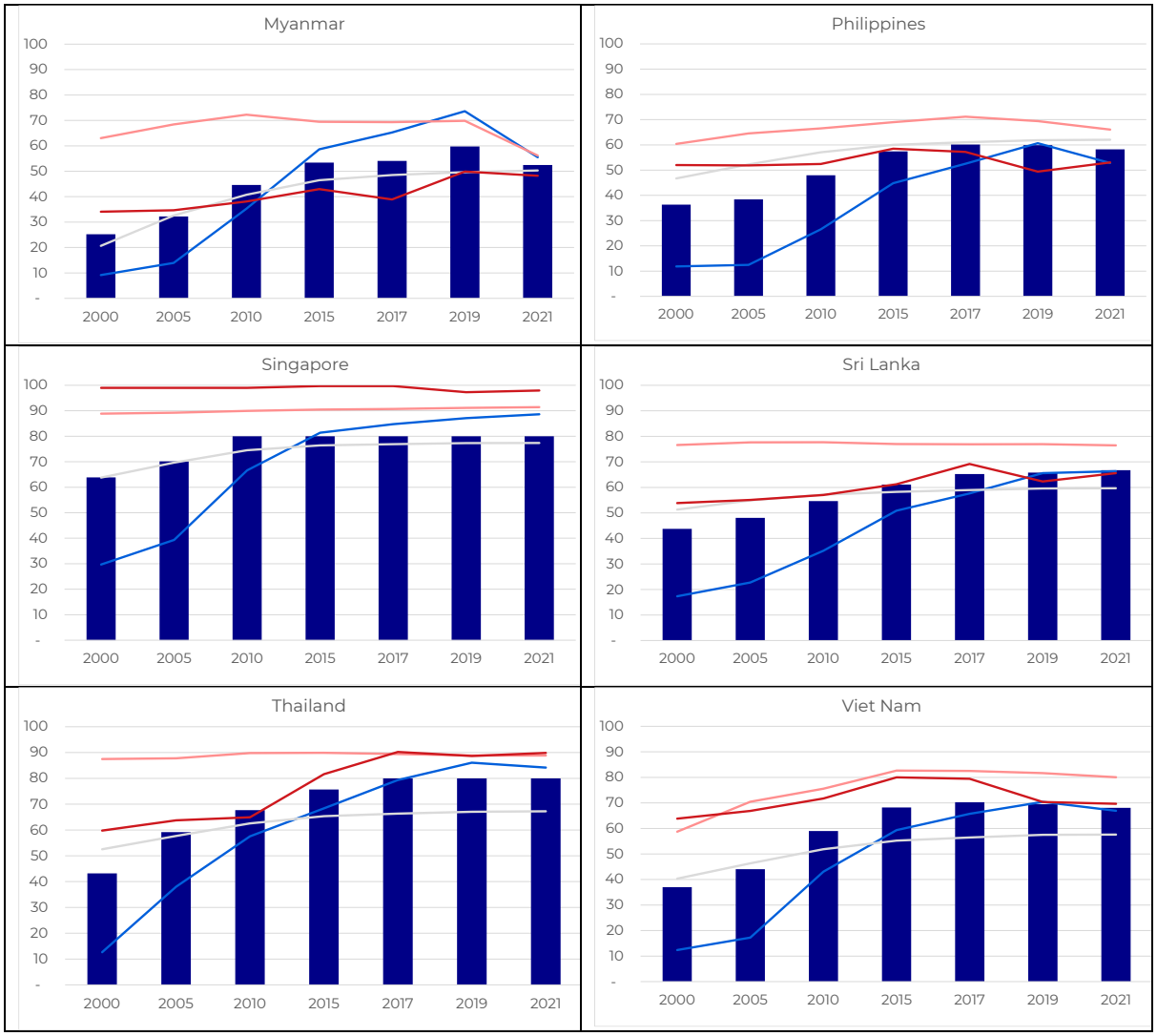




Country trends for the overall indicator and the components are shown in *Figure 10*. The overall index, shown as the bars, are capped at 80 whereas the other components, shown as lines, are not. These charts indicate that the contribution to improvement has varied by source from country to country. Probably not surprisingly, most countries have dramatically improved their capacity to address infectious disease over the period. Others have also advanced their scores against non-communicable disease treatment, access and maternal and early childhood risks.

Figure 10


Overall Health Service Coverage Index
Infectious Diseases
Non Comunicable Diseases
Reproductive, Maternal, Newborn and Child Health
Capacity and Access
Australia
Brunei Darussalam
Cambodia
China
India
Indonesia
Japan
Lao PDR
Malaysia
100
90
80
70
60
50
40
30
20
10
-
2000
2005
2010
2015
2017
2019
2021

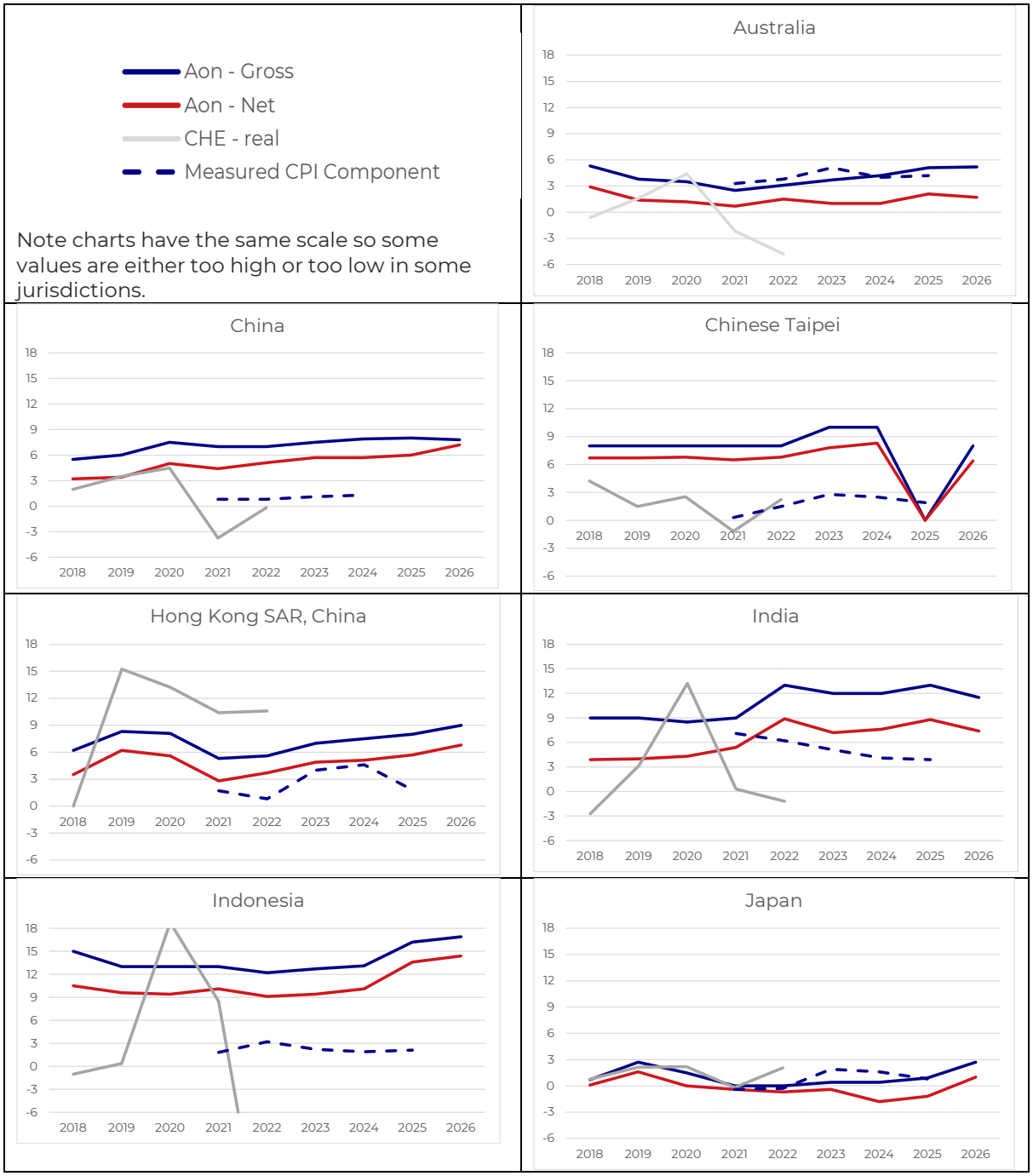


Source: WHO, Staff Analysis

Medical Inflation – Gross and Net

The following figure shows charts of each of the measures of medical cost increase for each country showing the consistent trend of high levels and, in most cases, increasing levels. Data is added in tables after the charts.

Figure 11: Comparing medical inflation measures in selected jurisdictions



Source: Author's Analysis

Table 12: Medical Inflation has been increasing across Asia – Gross reported results

Jurisdiction	Medical Claims Inflation Percent (Gross)					
	2021	2022	2023	2024	2025	2026
Australia	2.5	3.1	3.7	4.2	5.1	5.2
China	7.0	7.0	7.5	7.9	8.0	7.8
Chinese Taipei	8.0	8.0	10.0	10.0	n/a	8.0
Hong Kong	5.3	5.6	7.0	7.5	8.0	9.0
India	9.0	13.0	12.0	12.0	13.0	11.5
Indonesia	13.0	12.2	12.7	13.1	16.2	16.9
Japan	0.0	0.0	0.4	0.4	0.9	2.7
Malaysia	14.0	12.0	15.0	15.0	15.0	16.0
Philippines	8.0	8.0	9.0	14.0	15.0	14.0
Singapore	7.0	7.0	12.0	13.0	14.0	13.0
South Korea	7.5	8.0	7.5	10.0	10.0	11.5
Thailand	6.6	11.7	12.3	9.1	14.3	14.8
Viet Nam	8.7	5.5	6.5	6.7	12.9	12.2
ALL ASIA	**8.0**	**8.2**	**9.2**	**9.7**	**11.1**	**11.3**
World	**7.2**	**7.4**	**9.2**	**10.1**	**10.0**	**9.8**

Source: Global Medical Trend Rates Reports (Aon)

Table 13: Medical Inflation has been increasing across Asia – Net reported results

Jurisdiction	Medical Claims Inflation Percent Net over General Price Inflation					
	2021	2022	2023	2024	2025	2026
Australia	0.7	1.5	1.0	1.0	2.1	1.7
China	4.4	5.1	5.7	5.7	6.0	7.2
Chinese Taipei	6.5	6.8	7.8	8.3	n/a	6.4
Hong Kong	2.8	3.7	4.9	5.1	5.7	6.8
India	5.4	8.9	7.2	7.6	8.8	7.4
Indonesia	10.1	9.1	9.4	10.1	13.6	14.4
Japan	(0.4)	(0.7)	(0.4)	(1.8)	(1.2)	1.0
Malaysia	11.2	10.0	12.6	11.9	12.5	13.8
Philippines	5.1	5.0	5.3	10.8	12.0	11.1
Singapore	6.5	6.2	10.0	9.5	11.5	11.5
South Korea	7.1	7.1	5.1	7.7	8.0	9.7
Thailand	6.0	10.7	9.5	7.1	13.1	13.9
Viet Nam	4.8	1.6	3.3	2.4	9.5	9.7
ALL ASIA	**5.5**	**5.8**	**6.2**	**6.1**	**8.3**	**8.9**
World	**5.0**	**5.0**	**5.6**	**6.5**	**7.2**	**7.1**

Source: Global Medical Trend Rates Reports (Aon)

Table 14: Medical Inflation measured by CHE – real rate of change compared to GDP growth

Jurisdiction	Average Annual Percentage increase in Medical Claims in excess of Gross Domestic Product		
	Since 2000	Last 10 years	Last 5 years
Australia	1.23	1.37	-0.36
Brunei	-1.52	-0.16	-4.32
Cambodia	-1.44	-1.92	1.98
China	0.80	1.63	1.16
Chinese Taipei	3.62	6.52	9.76
Hong Kong	-0.98	-0.06	2.40
India	-0.98	-0.06	2.40
Indonesia	1.72	-0.78	-1.49
Japan	2.23	0.68	1.39
Laos	-3.36	-0.29	-4.40
Malaysia	2.04	1.23	1.06
Myanmar	4.14	7.26	0.47
Philippines	2.40	2.13	5.44
Singapore	1.76	3.97	2.55
South Korea	4.14	4.32	5.99
Sri Lanka	0.27	2.79	5.54
Thailand	2.51	4.28	6.80
Viet Nam	0.50	-0.85	-1.66

Source: WHO, Jurisdictional reports where WHO figures are not available, and Author's calculations

Table 15: Medical Price Inflation published as a component of overall price increases

Jurisdiction	Medical Price Inflation, Percent				
	2021	2022	2023	2024	2025
Australia	3.3	3.8	5.1	4.0	4.2
Brunei	0.1	0.2	0.0	0.1	n/a
China	0.8	0.8	1.1	1.3	n/a
Chinese Taipei	0.3	1.5	2.8	2.5	1.9
Hong Kong	1.7	0.8	4.0	4.6	1.8
India	7.1	6.2	5.1	4.1	3.9
Indonesia	1.8	3.2	2.2	1.9	2.1
Japan	(0.4)	(0.3)	1.9	1.6	0.8
Malaysia	0.4	2.2	2.2	1.8	1.5
Philippines	3.7	2.9	4.5	3.4	3.3
Singapore	1.1	2.2	4.5	3.9	2.3
South Korea	0.3	1.4	1.8	1.9	1.1
Thailand	0.2	1.1	1.6	0.1	n/a
Viet Nam	0.2	0.4	0.6	2.5 – 3.5	12.7

Source: Jurisdictional Statistical Agencies, Author's analysis

Sample Indicators that Influence Health Costs in Jurisdictions

Table 16: Selected Health Indicators – Infectious diseases, Road accidents

Jurisdiction	Tuberculosis		Vaccine Preventable Communicable Diseases						Road Traffic Mortality
	Incidence per 100,000 population		Measles				Diphtheria		Rate per 100,000 population
			Reported cases		Second Dose vaccine coverage		Reported cases		
	2024	2019	2024	2019	2024	2019	2024	2019	2024 report
Australia	6.9	6.8	57	286	92	94	9	7	4.5 declining
Brunei	65	71	0	1	99	98	0	0	
Cambodia	272	293	666	684	64	75	1	0	18.8 declining
China	49	58	1272	2974	95	98	0	0	17.4 declining
Hong Kong	66	84	9	90			0	0	
India	187	202	18530	10430	92	84	5634	9622	15.4 increasing
Indonesia	382	312	6328	1965	82	71	943	495	11.3 declining
Japan	9.8	14	45	742	96	93	0	0	2.7 declining
Laos	127	155	1	1119	66	50	26	73	16.4 declining
Malaysia	96	100	3791	1077	93	87	12	16	13.9 declining
Myanmar	482	322	30	5252	68	80	83	22	19.3 declining
Philippines	625	554	3844	48525	71	67	205	201	9.7 increasing
Singapore	43	42	12	152	93	92	0	0	1.9 declining
South Korea	35	58	49	194	96	96	0	0	6.9 declining
Sri Lanka	59	57	298	49	98	99	0	0	11.5 declining
Thailand	146	150	8202	5412	87	87	5	70	25.4 declining
Vietnam	182	176	7854	14156	95	92	11	53	17.7 declining

Source: WHO

Table 17: Selected Health Indicators – Obesity, NCDs

Jurisdiction	Dementia	Adult Obesity % BMI>30, both sexes				Noncommunicable disease - age standardised mortality rate per 100,000		Cancer		Diabetes		Cholesterol Levels	
	Prevalence per 100K WPR	Age Standardised		Crude Rate				Age Standardised Rate per 100,000		Age Standardised Prevalence (%)			
	2021	2022	2017	2022	2017	2021	2016	2022	2017	2024	2011	2018	2008
Australia	1170	30.24	27.88	31.82	29.15	280	290	462.5	324.3	7.4	6.6	3.1	3.4
Brunei	295	31.71	27.42	32.38	28.20	460	490	192.2		13.7	9.4	3.7	3.7
Cambodia	349	4.36	3.14	4.39	3.09	670	690	138.3		7.5	2.9	3.2	3.0
China	1190	8.28	6.11	8.21	6.22	490	520	201.6	228.9	11.9	8.8	3.3	3.2
Hong Kong										8.2	7.6		
India	295	7.27	5.52	7.21	5.40	550	580	98.5	113.6	10.5	9.0	3.1	3.4
Indonesia	398	11.23	8.28	11.50	8.51	590	670	136.9		11.3	5.1	3.5	3.2
Japan	2640	5.54	4.59	4.94	4.24	230	230	267.1	279.5	7.7	8.1	3.2	3.4
Laos	297	8.01	6.16	7.76	5.81	690	710	154.5		6.7	3.3	3.2	3.1
Malaysia	483	22.10	18.91	22.40	19.11	530	530	142.1		21.1	12.1	4.2	4.1
Myanmar	457	7.43	6.22	7.54	6.22	640	680	135.5		6.7	7.1	3.7	3.4
Philippines	370	8.74	7.07	8.74	7.01	870	670	185.4	159.5	7.5	9.7	3.9	3.7
Singapore	765	13.88	10.55	13.54	10.60	220	240	231.1		11.4	9.5	3.7	3.6
South Korea	1350	7.33	5.40	6.73	5.20	220	260	234.7	260.4	9.6	7.5	3.3	3.5
Sri Lanka	687	10.56	7.87	10.61	7.97	410	480	106.9		10.2	7.5	3.2	3.1
Thailand	989	15.38	12.43	14.51	12.15	390	360	154.4	134.0	10.2	7.5	4.0	3.9
Vietnam	530	2.02	1.32	2.08	1.33	550	580	150.8		3.4	3.2	3.5	3.2

Source: WHO, World Population Review, International Diabetes Federation, World Cancer Research Fund, Global Cancer Observatory.

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Our earlier papers on protection gaps:

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